Annual
Quality Management
And
Utilization Management
Program Evaluation
2013
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I. Executive Summary

ValueOptions, CT serves as the behavioral health administrative service organization for the Connecticut Behavioral Health Partnership (CT BHP) and manages the behavior health care for nearly 800,000 Medicaid members. The CT BHP is a partnership between the Department of Social Services, Department of Children and Families and Department of Mental Health and Addiction Services. ValueOptions, CT’s expected role is to be the primary vehicle for organizing and integrating clinical management processes across the payer streams, supporting access to community-services, assuring the delivery of quality services and preventing unnecessary institutional care. Additionally, ValueOptions, CT is expected to enhance communication and collaboration within the behavioral health delivery system, assess network adequacy on an ongoing basis, improve the overall delivery system and provide integrated services supporting health and recovery by working with the Departments to recruit and retain both traditional and non-traditional providers.

Overall, the Medicaid membership increase by 2.4% between 2012 and 2013. The adult membership increased more significantly with a 3.3% increase over last year when compared to the youth membership which increased by only 1.1%. The Family Single eligibility category continues to be the largest membership followed by Medicaid Low Income Adults.

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Total Membership</th>
<th>Youth (0-17)</th>
<th>Adults (18+)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Single</td>
<td>514,271</td>
<td>318,679</td>
<td>206,828</td>
</tr>
<tr>
<td>Family Dual</td>
<td>6,227</td>
<td>9</td>
<td>6,218</td>
</tr>
<tr>
<td>HUSKY B</td>
<td>20,550</td>
<td>19,559</td>
<td>1,712</td>
</tr>
<tr>
<td>DCF Limited Benefit (D05)</td>
<td>441</td>
<td>441</td>
<td>0</td>
</tr>
<tr>
<td>Aged, Blind and Disabled (ABD) Single</td>
<td>38,209</td>
<td>28</td>
<td>38,186</td>
</tr>
<tr>
<td>ABD Dual</td>
<td>59,589</td>
<td>0</td>
<td>59,589</td>
</tr>
<tr>
<td>Long Term Care (LTC) Single</td>
<td>2,597</td>
<td>1</td>
<td>2,596</td>
</tr>
<tr>
<td>LTC Dual</td>
<td>22,455</td>
<td>0</td>
<td>22,455</td>
</tr>
<tr>
<td>Medicaid Low Income Adults (MLIA)</td>
<td>145,460</td>
<td>47</td>
<td>145,433</td>
</tr>
<tr>
<td>Charter Oak</td>
<td>6,605</td>
<td>0</td>
<td>6,605</td>
</tr>
<tr>
<td>Total Membership</td>
<td>789,622</td>
<td>333,448</td>
<td>468,288</td>
</tr>
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</table>

A. Overview of the Quality Management (QM) Program

The ValueOptions, CT Quality Management (QM) Program was initiated with the implementation of the original contract in 2006. The QM Program serves as the overarching structure to evaluate continuously the effectiveness of ValueOptions CT as the ASO for the BHP and to ensure that the clinical and support services offered within the CT BHP live up to their promise for the youth, families and adults served by the program. The QM Program identifies the key performance indicators across functional areas within the engagement center that affect the operation and develops the QM/UM project plan for the coming year. Over the course of the year, the indicators are monitored, findings are analyzed, trends, barriers identified, and then actions initiated to improve performance when necessary.
The engagement center’s annual Quality/Utilization Management program evaluation assesses the overall effectiveness of the QM Program including the effectiveness of the committee structure, the adequacy of the resources devoted to it, practitioner and leadership involvement, the strengths and accomplishments of the program with special focus on patient safety and risk assessment, and performance related to clinical care and service. Progress toward the previous year’s project plan goals is also evaluated. A review of each of the goals is included within this evaluation along with a description of each goal and sub-goal, commentary regarding their completion status, and recommendations for whether to carry them over into the project plan for the following year. The results of this program evaluation, together with the additional goals that reflect the strategic planning done collaboratively with DSS, DMHAS and DCF will be used to formulate the 2013 Project Plan.

B. Key Accomplishments of the QM Program in 2013 include:

- Integration of large datasets, which included Medicaid claims data, DMHAS encounter data, DCF “Flex Fund” data and ValueOptions authorization data to obtain a fuller picture of utilization of behavioral health services by CT Medicaid members.
- Began the use of SAS (Statistical Analysis System) by data analytic staff that expedites and allows for more complex data analytics.
- Increased the use of claims-based reporting and decreased the reliance on authorization data. VO CT now produces claim-based reports for Home Health, Inpatient, and IICAPS levels of care.
- The development of claims-based reporting allowed VO CT to program first of many HEDIS measure reports and a Home Health completely claims-based PARs program.
- Expanded claims-based reporting beyond focus on behavioral health; medical and pharmacy data are incorporated into ValueOptions CT reports
- Worked with DSS and DCF to develop pharmacy reports concerning CT youth who are being treated with more than one anti-psychotic for longer than 30 days.
- Continued PAR programs for Adult Inpatient Hospitals, Pediatric Inpatient Hospitals and PRTFs.
- Developed enhanced provider profiles for Home Health agencies and started on-site PAR meetings with Home Health providers who serve the most members.
- Developed dashboard to provide real-time data to adult inpatient hospitals; rollout to be completed in first quarter 2014.
- Completed Connect-to-Care meetings with adult hospitals to further develop connections between hospitals and community providers and inform discharge planning.
- Completed first round of surveys of ECC providers, including communication of survey results, development of corrective action plans, as needed, and began final round of follow-up surveys.

C. Key Accomplishments of the UM Program in 2013 include:

- The clinical department achieved 100% passing score on the annual IRR with an average score of 96%.
- The child/adolescent discharge delay rate in CY 2013 was at the lowest annual percent achieved in the past 6 years – 8.4%.
- The inpatient ALOS for all youth in CY 2013 was the lowest annual rate ever recorded over the past 6 years – 12.71 days.
- The adult ICMs have implemented an on-site complex care rounds in several inpatient units and detox facilities.
Participated in regional Connect-to-Care meetings which have focused on improving coordination of care between providers.

Continued to implement co-management meetings with CHN to effectively coordinate care for those HUSKY members who experience medical and behavioral health needs.

Worked collaboratively with provider relations department to implement an adult ICM and community peer model on-site at St. Francis hospital.

II. Evaluation of the Overall Effectiveness of the ValueOptions, CT QM Program Structure

A. QM Committee Structure

The following QM committee structure is in place at the time of this evaluation:

**ValueOptions, CT Quality Management Committee (QMC)**

The QMC was established to provide oversight of the VO-CT QM program. The QMC is co-chaired by the Vice President (VP) and the Assistant Vice President (AVP) of QM. The QMC reports to the ValueOptions National Quality Council and is also guided by the Senior Management Quality Management Steering Committee (also known as CORE) which is attended by representatives of the Departments as well as ValueOptions, CT senior leadership.

The membership of the QMC includes representatives from all departments within the Engagement Center including the leadership of the engagement center. Included are:
- Chief Executive Officer
- Chief Operating Officer
- Medical Director or designee
- VP of Quality Management
- AVP of Quality Management and QM staff
- VP of Recovery and Clinical Operations
- VP of Health and Wellness
- VP of Provider and Customer Relations
- Clinical Director
- Director of Community Support
- Director of Customer Service
- Director of Human Resources
- Director of Finance
- Director of Provider Relations

The QMC met on a quarterly basis in 2013 and the focus of the committee was to review the progress and performance on the performance targets and quality improvement activities – PARs programs. Performance on the operational indicators continues to be above expectations and therefore other measures were reviewed.

**Safety and Risk Management Sub-Committee**

The Safety and Risk Management Sub-Committee reports to the QMC and is co-chaired by the Medical Director and the AVP of Quality Management. In addition to the co-chairs, the membership of the committee included:
- VP of Quality Management (ad hoc)
- QM Coordinator
Quality Specialist II
Clinical Supervisor
Network Development Specialist
Regional Network Manager

The Safety and Risk Management committee continues to meet weekly to review all of the potential adverse incidents and quality of care/service concerns. With respect to adverse incidents, the committee continues to verify that high risk members are successfully connecting to care post stabilizing on an inpatient unit. In addition, the committee assess whether or not there is quality of care concerns on the part of the provider which provided care to the member prior to the adverse incident. With respect to quality of care/service concerns, the potential concerns are reviewed and attempts are made to substantiate the concern via the Connect system. In both cases, concerns are tracked and once provider trends are identified they are presented in the sub-committed before being reported up through the QMC.

**Regional Network Management Sub-Committee and Provider Analysis and Reporting (PARs) Workgroup**

The Network Management Sub-Committee meets weekly and reports to the QMC. The sub-committee is chaired by the Director of PARs and VP of QM. Its members include:

- Regional Network Managers
- VP of QM
- AVP of QM
- QM Analysts
- CEO (*Ad Hoc*)
- Medical Directors (*Ad Hoc*)

The primary focus of this committee continues to be on developing strategies to improve systems of care, with particular focus on addressing issues generated by the PARs programs. One of the issues that came out of the PARs meeting was the challenges around connecting members to care following inpatient stays. Based on the concerns, Connect-to-Care meetings were set up between inpatient providers and local network providers to begin the dialog around ways to better assist member around discharge planning. The level of care specific, provider workgroups continue to work on developing new indicators and fine tuning existing measures. As measures become more established and no longer need modifications, they are moved from a paper based product to an on-line dashboard. The sub-committee was instrumental in assisting in the creation of the adult inpatient on-line dashboard which is similar to the child/youth inpatient dashboard and was presented to adult inpatient providers during the PARs meetings at the beginning of 2014.

In addition, this committee continues to provide oversight of the five (5) Geo-Teams. The Geo-Teams include VO staff members from all key functional areas who are involved with facilities and programs in specific geographic regions. These teams reviewed PARs data, denial and appeals data and discussed strategies to address concerns specific to the geographic regions. The Geo-Teams members also provide their perspective on the findings, and develop strategies for improving the performance of the facilities and programs in the region.
Consumer and Family Advisory Sub-Committee

The Consumer and Family Advisory Sub-Committee was established in 2006 and meets monthly. In 2013 the sub-committee was co-chaired by a Family Peer Specialist and a family member. The committee membership includes:

Peer Support staff
Director of Customer Service
Director of Community Support
Families of members
Member advocates
Consumers

The focus of this sub-committee continues to be as an advisory committee for both VO operations as well as provider operations and provides feedback on improvements that could be made to either. In 2013, the sub-committee addresses multiple concerns such the effectiveness of the transportation services, experience of the families and children in emergency departments and concerns specific to the youth population (18-25 years old). A separate Youth sub-committee was established, which is led by the Family Peer Specialist, an adult member and a youth member. This sub-committee focused on the youth members being able to find their voices and being able to effectively communicate their needs.

Assessment and Recommendations of QM Committee Structure and Effectiveness:

The QM committee and the sub-committees continue to play major role in the disseminating of information to the staff about performance on the key indicators and continuing to assess performance on the ongoing operations of engagement center as well as the operations of providers. Participation in the committees allows new staff to better understand how data plays an integral role in decision making relative to the operation of the engagement center. The committees also ensure that there is an ongoing process that allows for the members and providers to contribute their perspective in the decision-making process. The committee structure is going to be critical in maintaining the quality-minded focus of the engagement center, particularly as new staff members are added to the QM department and a new CEO comes on board in 2014.

B. Adequacy of Resources

The following chart is a summary of the positions that support the Quality Management program with credentials and percentage of time devoted to quality management activities.
In 2013, the QM department experienced some significant restructuring based on the changing needs of the department and expectations of the contract. In March, a plan was developed to

<table>
<thead>
<tr>
<th>Title</th>
<th>Credentials</th>
<th>Percent of time per week devoted to QM</th>
</tr>
</thead>
<tbody>
<tr>
<td>SVP of Quality and Innovation</td>
<td>PhD</td>
<td>100%</td>
</tr>
<tr>
<td>Chief of Research and Development</td>
<td>PhD</td>
<td>100%</td>
</tr>
<tr>
<td>Assistant VP of QM</td>
<td>LCSW</td>
<td>100%</td>
</tr>
<tr>
<td>Assistant VP of Analytics and Innovation</td>
<td>Master's level</td>
<td>100%</td>
</tr>
<tr>
<td>Director of PARs</td>
<td>JD</td>
<td>100%</td>
</tr>
<tr>
<td>Regional Network Managers (11 FTEs)</td>
<td>Master's level</td>
<td>100%</td>
</tr>
<tr>
<td>Quality Analysts - Team Lead</td>
<td>Master's level</td>
<td>100%</td>
</tr>
<tr>
<td>Quality Analysts (7 FTEs)</td>
<td>4 Master's level + 3 Vacancies</td>
<td>100%</td>
</tr>
<tr>
<td>Statistician</td>
<td>PhD</td>
<td>20%</td>
</tr>
<tr>
<td>QM Coordinator - Complaints/Appeals (3 FTEs)</td>
<td>Bachelor's level</td>
<td>100%</td>
</tr>
<tr>
<td>Contract Monitor</td>
<td>Associate's level</td>
<td>100%</td>
</tr>
<tr>
<td>QM Specialists II - Auditor (2 FTEs)</td>
<td>Master's level/Licensed clinicians</td>
<td>100%</td>
</tr>
<tr>
<td>Director of Compliance</td>
<td>Bachelor's level</td>
<td>50%</td>
</tr>
<tr>
<td>CEO/VP Service Center</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>Chief Operating Office</td>
<td>PhD</td>
<td>30%</td>
</tr>
<tr>
<td>Medical Director</td>
<td>MD</td>
<td>40%</td>
</tr>
<tr>
<td>VP of Clinical Operations</td>
<td>Master's level</td>
<td>30%</td>
</tr>
<tr>
<td>Director of Utilization Management</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>VP of Health and Wellness</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Health and Wellness</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Community Support</td>
<td>RN</td>
<td>20%</td>
</tr>
<tr>
<td>VP Member and Provider Support</td>
<td>Master's level</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Customer Service</td>
<td>Extensive experience</td>
<td>20%</td>
</tr>
<tr>
<td>Director of Provider Relations</td>
<td>Master's level</td>
<td>20%</td>
</tr>
</tbody>
</table>
address the staffing, training and hardware/software needs of the department. The first area that the plan addressed was the Regional Network Management group. With the growth in the number of PARs programs and the congregate care RNMs joining the team, the absence of a PARs Director became more important. The VP of QM had been overseeing this group since the departure of the PARs director in 2012. In order to free up the VP of QM to oversee the entire QM operation, a new PARs Director was hired and started in June of 2013.

The quality analyst (QA) team underwent the most transition in the past two years. The skills necessary to do this job have changed dramatically. Previously, skills in using Excel to develop graphs and charts, PARs profiles, and compute change scores were adequate. At present, the QA group requires far more advanced understanding of measurement methodology and statistical skills and, increasingly, claims coding to support the needs of the contract. While several QAs with a statistics background and experience with SPSS were added, additional training in the use of SAS (Statistical Analysis System) was required to allow more complex analysis of large, integrated data sets. This training would allow staff to work more efficiently with data to interact more effectively with the high level statistician recently hired into the department. The SAS software was purchased by the end of 2013, and training of the staff commenced shortly thereafter. The statistician, who has strong skills in SAS, was identified to enhance the skills development between trainings.

The final part of the plan identified the need for a research and development position to support the statistical, methodological, and analysis needs of the department. In the past, the QM department was able to meet the periodic needs of the contract in this area by bringing in a consultant. This year it became clear that the demands for these skills were too consistent for a consultant to be adequate. A full time, doctoral level person was needed, who had the skills to develop methodology and to answer the questions that are being asked of the QM department.

In October, several new positions were added in the QM department to address the above mentioned needs. A research and development position was established and the existing VP of QM assumed this new title as the Chief of Research and Outcomes. Two additional positions were created to lead the newly structured department: A new Senior VP of Quality and Innovation and an Assistant VP of Analytics and Innovation.

C. Practitioner Involvement

Network providers continue to be actively involved in the VO QM program particularly in the continued development of the PARs programs. Each of the PARs programs for the different levels of care has work groups consisting of network practitioners/providers. They have an active voice in the indicators that are measured and methodologies for creating the measures are presented to the providers as well. In addition, the Quality and Access subcommittee is another avenue for provider involvement in the QM program. All performance targets findings are presented to this provider group for feedback and discussion. The providers provide a valuable perspective to the program.

D. Leadership Involvement

A significant strength of the QM program is the continuing involvement of engagement center leadership at the highest level. The CEO and members of the senior management team are all active participants in the day to day operations of the QM Program. Their active involvement provides a clear message to all VO, CT staff regarding the importance of their involvement in and support of the activities. Newly hired members of the leadership team were quickly
introduced to the quality culture of the engagement center and to the central role that data plays in decision making.
The CEO brings her special expertise and experience in the development of the PARs and Performance Incentive programs. When possible, she works closely with the Regional Network Management team to strategize and shape their projects. The Medical Directors also plays an influential role in the Safety and Risk Committee, the development of protocols for handling high risk cases and the PARs Programs. They are active members of the QMC and provide input to the design of Quality Improvement Activities, particularly those involving clinical activities. They help monitor utilization trends and contribute to the oversight of the appeals process.

E. Patient Safety

The engagement center continues to be committed to maintaining patient safety and mitigating risk to members. The adult members continue to present with the highest level of risk and adverse incidents are carefully reviewed to ensure that processes are followed which assist in determining if members are connecting to care following a hospitalization. High risk members are identified and rounded with the Medical Directors to ensure that risk is being mitigated prior to being discharged and that discharge plans are appropriate for the member circumstances.

III. Evaluation of the Overall Effectiveness of the UM Program Structure

A. UM Committee Structure and Effectiveness of Structure

Utilization Management Sub-Committee

The Utilization Management Sub-Committee meets weekly and reports to the QMC. The sub-committee is co-chaired by the VP of Recovery and Clinical Operations and the Medical Director. In addition to the co-chairs, the membership of the committee included:

VP of Recovery and Clinical Operations
Associate Medical Director - Adults
Associate Medical Director - Children
Chief Operating Officer
Director of Intensive Care Management and Peer Support Services
VP of Quality Management
QM Quality Analyst Staff

The UM committee meets on a weekly basis. The goal is to understand the clinical landscape and work as a group to find better ways to positively impact the system through data. The clinical supervisors joined the makeup of the UM committee meeting on 2013 as an opportunity to expand their understanding of the UM process. Their presence has added to the complexity of the group discussion. The committee develops new reports that support innovative UM strategies, as well as evaluates the utility of current reports. UM strategies and interventions are consistently being reviewed for effectiveness and reliability.

B. Adequacy of UM Resources

The UM program resources are reported in the UM program description. There was a 25% turnover in the Clinical department in 2013. Of those 25% who terminated, ½ had been employed less than one year and none of the other employees worked for greater than two years. There were several ICM positions vacant, requiring ICMs from neighboring regions to
cover ICM cases. By the end of the year all ICM positions had been filled. There were also several Care Manager positions open throughout the year, but those positions were filled fairly soon after becoming vacant. There have been no changes to the clinical management staff during 2013.

C. Practitioner Involvement

There is active involvement by CT providers/practitioners in UM activities. Individual provider meetings occur frequently and include: onsite rounds, clinical documentation trainings, OATP initiative discussions, member specific care planning meetings. The UM program often partners with member of the Quality team to engage providers in PAR discussions or clinical workshops. Providers are also involved in multiple UM/QM Committees and Sub-Committees, including those that provide oversight of the Partnership at the highest level. Please see the 2014 QM Program Description for details about those committees that involve providers.

D. Leadership Involvement

The CEO and members of the senior management team are all active participants in the operations of the UM Program. Their active involvement provides a clear message to all VO, CT staff regarding the importance of their daily activities while also providing sound clinical and professional. The VP of Clinical Operations attends each weekly staff meeting and provides ongoing updates on initiatives and performance targets. Clinical managers also take time to explain how each clinician’s individual contributions influence and change the behavioral health delivery system in CT.

E. Patient Safety

Clinical staff members play a major role in the oversight and planning for member safety. During each call for authorization, clinicians are gathering clinical information to better understand members’ risk factors. A clinical dialogue between staff and providers ensure that safety measures are being taken and individualized treatment plans are being created and implemented. There are occasions that Adverse Incidents are reported. Clinicians submit all AI documentation to the Quality Department for further review of the case and continue to work with providers to ensure that discharge plans are secure and specific to each member’s needs.

IV. Evaluation of 2013 QM/UM Project Plan

Goal 1: Review and approve 2012 ValueOptions, CT QM/UM Program Evaluation, 2013 ValueOptions, CT QM Program Description and 2013 ValueOptions, CT QM/UM Project Plan (Contract reference: M.3.1, M.3.2, M.3.3)

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A-C. The 2012 QM/UM Program Evaluation, the 2013 QM Program Description, and the 2013 QM/UM Program Project Plan were submitted to the Departments on April 1, 2013 and then the QM Program Description and QM/UM Project Plan were resubmitted on June 3, 2013 following discussions with the departments about the content and revisions. Formal approval of the documents by the Departments was received on June 7, 2013.

Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

**Goal 2: Ensure timely response and resolution of member/provider complaints and grievances (Contract reference: Exhibit E; 20 A-E)**

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

**A – D. Total Number of Complaints and Grievances by Member and Provider**

![Chart](chart.png)

A total of 142 complaints were received by the Quality Management department during 2013, which is a 37.9% increase over the previous year. Due to a possible logic error within the VO management information system (MIS) and human error when categorizing complaints, the physical count of complaint inquiries does not match the numbers reported out on the 20 A-D Complaints Report. There were a total of sixteen (16) complaints that were improperly categorized by type of complainant in the VO MIS. In all, 139 complaints were assessed (or handled) during 2013, which included three (3) complaints that were carried over from the previous year. Of all the complaints handled in 2013, 135 were resolved within the year. 126 complaints were resolved within 30 days of receipt. A total of eight (8) complaints were resolved within 31-45 days with the appropriate permissions granted by the complainant. One was closed by QM outside of the 45 days in February but the complaint was actually resolved by the Peer Department in December 2012, one day after the complaint was received.
E. **Average Number of Days to Resolution**

![Graph showing average number of days to resolve complaints]

The annual average time to resolve a complaint increased 68.2% from 2012 (15.30 days) to 2013 (25.74 days). Although it increased it continues to be below the standard of 30 days.

F. **Percent of complaints resolved within 30 days**

Of all the complaints handled in 2013, 135 were resolved within the year. 126 complaints were resolved within 30 days of receipt – 93.33%. A total of eight (8) complaints were resolved within 31-45 days with the appropriate permissions granted by the complainant. One was closed by QM outside of the 45 days in February of 2013 but upon review it was identified that the complaint was actually resolved by the Peer Department in December 2012, one day after the complaint was received.

G. **Most frequent reasons for complaints**

**Adult Member (18+) Complaints:** In CY’13 there were 87 adult member complaints received; the reasons were:

- Thirty-three (33) were classified as issues related to clinical services from providers.
- Twenty-four (24) involved issues with inappropriate provider attitude and/or behaviors.
- Twelve (12) referenced billing and financial issues.
- Five (5) were regarding access to services issues.
- Four (4) related to the contractor’s performance.
- Three (3) involved transportation issues.
- Three (3) related to provider network accuracy and/or incorrect referrals.
- Two (2) issues regarding the physical quality of the provider’s office.
- One (1) related to an authorization issue.

**Youth Member (0-17) Complaints:** In CY ’13, 25 youth member complaints were received; the reasons were:

- Nine (9) were classified as issues related to clinical services from providers.
- Five (5) involved issues with inappropriate provider attitude and/or behaviors.
• Three (3) were regarding access to services issues.
• Three (3) referenced billing and financial issues.
• Two (2) were classified as issues with the contractor’s performance.
• Two (2) involved issues with transportation.
• One (1) related to an issue with authorization for services.

Provider Complaints: In CY ‘13 there were 30 provider complaints received and the reasons included:

• Twenty-one (21) complaints were classified as issues with the contractor’s performance.
• Three (3) involved an issue with member transportation.
• Two (2) were regarding access to services issues.
• Two (2) were classified as complaints regarding benefits.
• One (1) related to an authorization issue.
• One (1) involving a clinical issue with another provider.

Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

Goal 3: Promote patient safety and minimize patient and organizational risk from adverse incidents and quality of care and service concerns. (Contract reference: M.11)

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. Number of quality of care and service identified (by youth and adult members)

In 2013, there were 311 possible quality of care/service concerns identified by VO staff and submitted to QM for further review. There was a 60.3% increase in volume of concerns submitted to QM between 2012 and 2013. This increase may be largely due to an increase in the frequency in trainings that was provided to the staff in Geo Teams and other small group staff meetings. All of the quality of care/service concerns submitted are reviewed by a licensed clinician and elevated to the AVP of QM as needed if immediate intervention is deemed necessary for reasons of member safety. All submissions were reviewed by the Safety and Risk Management committee to determine if the submissions were quality of care/service and what appropriate actions needed to be taken as follow up. Of the 311 possible concerns, the committee deemed that 103 (33.1%) were quality of care/service concerns and would be tracked and trended until which time trends warranted actions. There was a 28.8% increase in the number identified of concerns between 2012 and 2013. All concerns related to enhanced care clinics (ECCs) and access to care concerns are forwarded to the assigned Regional Network Manager and they address the concerns with the providers directly. Concerns related to the residential treatment center and group homes are forwarded to the assigned Congregate Care Network Manager and they address the concern with the providers directly. These concerns are also forwarded to the Department of Children and Families if it is clear that the Department is not already aware of the concern.

Of the remaining 208 (66.9%) concerns submitted to QM, 195 were deemed not to be actual quality of care/service concerns and were issues that were more apt to need resolution in the
UM department. Thirteen (13) are awaiting additional information from providers in order to make a determination.

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Submissions</td>
<td>203</td>
<td>283</td>
<td>227</td>
<td>183</td>
<td>194</td>
<td>311</td>
</tr>
<tr>
<td>Quality of Care/Service</td>
<td>203</td>
<td>237</td>
<td>95</td>
<td>34</td>
<td>80</td>
<td>103</td>
</tr>
<tr>
<td>Not Quality of Care</td>
<td>0</td>
<td>46</td>
<td>130</td>
<td>22</td>
<td>114</td>
<td>195</td>
</tr>
<tr>
<td>Undetermined</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>127</td>
<td>0</td>
<td>13</td>
</tr>
</tbody>
</table>

Of the 103 identified quality of care/service concerns, 18 (17.5%) involved youth members, which was a 55.0% decrease over last year. Eighty five (85) of the 311 involved adult members (82.5%), which was a 142.9% increase in the volume of identified concerns on the behalf of adults from 2012.

**Percentage by Category/Sub-category**

After reviewing the concerns, each are categorized by the type of concern for tracking and trending purposes. The majority of the concerns are clinical practice-related issues (96 out of 103, 93.2%), which is higher than in previous years.
Percentage by Level of Care

Once sorted for tracking and trending, the concerns are further reviewed by level of care.

Of the 18 concerns identified for youth members, the highest volumes were regarding, in order, inpatient and psychiatric residential treatment (33.3%, each) and emergency departments (11.1%).

Eighty five concerns were identified for adult members, the majority of which revolved around issues within a partial hospitalization program (42.4%), intensive outpatient (25.9%), and inpatient services (20.0%).

The following grids outline the quality of care issues by their identified level of care with volumes for the specific providers.
There were a total of eighteen (18) quality of care concerns identified involving youth members, spread across thirteen (13) providers, during CY 2013. Eleven (11) providers each had one quality of care concern and will continue to be monitored for future trends.

Village for Families & Children PRTF had the highest rate of identified quality of care/service concerns for youth, with a total of four (4) concerns. These concerns were addressed by setting up joint meeting with the program and DCF. At the same time, there were concerns identified by the VO staff with the Village PRTF, DCF was also receiving an increase in calls to the CARE line regarding this program. The Village indicated that they were aware of the issues and had established a corrective action plan which they shared with VO and DCF. The corrective action plan addressed the immediate issues, but did not seem to address the more systemic issues related to the increase in severity of the population served as indicated by concerns continuing to be identified into 2014.

Hospital of Central CT emergency department had three (3) identified quality of concerns all relating to clinical practice-related issues involving a delay in treatment and keeping youth in the emergency room longer than necessary. The concerns were address by the Clinical department with several meetings with the hospital to share with them the assistance that can be provided by VO through the ICM program and VO’s daily calls to the emergency department. VO’s participation in rounds was established.
Concerns with Stonington’s PHP/IOP program were addressed by conducting quality of care audits on January 22, 2013 and then requesting a corrective action plan in response to the poor performance on the audit. A follow up audit was conducted on September 13, 2013 in order to determine if progress had been made in implementing the corrective action plan. It was clear during the follow up audit that some progress had been made and the results were shared with the both the State partners as well as the program. Following the review of the results from the second audit, it was decided that auditing would persist on a regular basis in order to see that the quality improvements were continued and any gains maintained.

Concerns with St. Vincent’s Hospital have been raised both by UM and QM, which have been discussed in Geo Teams to identify strategies to address the issues. Due to the several staffing changes that occurred in both the clinical and quality department, multiple iterations of action steps have been created but because of the transitions have lacked traction. Going forward, the efforts around addressing the concerns with St. Vincent’s will be led by the AVP of QM based on the above noted concerns.

Concerns with Hospital of Central CT for adult members were related to medications not being changed as quickly as might be clinical appropriate. The concerns were addressed by the Clinical department in the meetings mentioned above under the youth concerns. VO recommended participation in hospital rounds as a way to assist in communication of expectations.
B. Number of adverse incidents identified (by youth and adult members)

In CY ’13 a total of 655 events were submitted as possible adverse incidents. Of this total, 242 were deemed adverse incidents and met the ValueOptions, Inc. criteria (i.e. member was receiving services or recently discharged from services managed by ValueOptions, Inc. and/or required emergent or urgent treatment following the incident) and were given a risk severity rating. Annually, we saw a 12% decrease in the volume of adverse incidents during CY ’12 (276) to CY ’13 (242). Incidents are typically self-reported by providers during authorization reviews conducted by care managers.

The remaining 413 were events involved a member engaged in high risk behaviors, but did not meet the criteria as an adverse incident (i.e. not receiving services, not recently discharged from services managed by ValueOptions Inc., and/or did not require urgent or emergent treatment following the incident).

Of the 242 adverse incidents reviewed in CY 2013, 16.1% (39) involved youth members and 83.9% (203) involved adult members.

The two hundred and forty two (242) adverse incidents were categorized by severity rate based on both the client’s enrollment in treatment at the time of the event and the level of treatment they required after the event.

- One hundred and twenty (120) were categorized as Minimal risk.
- Ninety seven (97) were categorized as Moderate risk.
- Twenty five (25) were categorized as Major risk.
  - Nineteen incidents involved self-inflicted harm by a member.
    - (17) adults, (2) youths
  - Five incidents involved the unanticipated death of the member.
    - (4) adults, (1) youth
  - One involved the elopement of a member from a behavioral health setting.
    - (1) youth

All critical incident and significant events are reported to the departments or were determined to have already been reported to the departments by the facility or provider.
Frequency of adverse incident identified

<table>
<thead>
<tr>
<th>Adverse Incident Category</th>
<th>CY '08</th>
<th>CY '09</th>
<th>CY '10</th>
<th>CY '11</th>
<th>CY '12</th>
<th>CY '13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Property Damage</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Serious Adverse Reaction to Treatment</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Medication Errors</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other Occurrences</td>
<td>-</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Unanticipated Death</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Elopements</td>
<td>-</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Human Rights Violations</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Violent/Assaultive Behavior (non-lethal)</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>5</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Injuries (Accidents): Urgent or Emergent</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Sexual Behavior</td>
<td>5</td>
<td>12</td>
<td>5</td>
<td>10</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Self-Inflicted Harm</td>
<td>7</td>
<td>5</td>
<td>169</td>
<td>226</td>
<td>252</td>
<td>228</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
<td><strong>29</strong></td>
<td><strong>193</strong></td>
<td><strong>251</strong></td>
<td><strong>276</strong></td>
<td><strong>242</strong></td>
</tr>
</tbody>
</table>

Trends by provider

In 2013, there were fifteen (15) adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Yale New Haven Hospital, including their inpatient, outpatient, and intensive outpatient programs. Fourteen incidents involved self-inflicted harm by the member and one involved the unanticipated death of a member. Five (5) were classified as a major risk, six (6) were classified as a moderate risk and four (4) were classified as minimal risk.

There were nine (9) adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Bristol Hospital including their outpatient, intensive outpatient and inpatient programs. All of the incidents involved were categorized as self-inflicted harm and were further categorized as follows; One (1) major risk, two (2) moderate risks, and six (6) minimal risks.

There were nine (9) adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at Hartford Hospital, including their inpatient program. The incidents were categorized as follows; six (6) involved self-inflicted harm of the member, one involved the unanticipated death of the member, one involved violent or assaultive (non-lethal) behavior and one (1) involved an injury to the member. These categories were further categorized as two (2) major risks, two (2) moderate risks, and five (5) minimal risks.

There were nine (9) adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment at St. Vincent’s Medical Center, including their inpatient program. Seven of the incidents involved were categorized as self-inflicted harm and were further categorized as follows; One (1) major risk, two (2) moderate risks, and four (4) minimal risks. The remaining two (2) incidents involved sexual behaviors and were assessed as a minimal risk.

Apt Foundation also had a total of nine (9) adverse incidents reported regarding members either recently (within two weeks of discharge) or currently in treatment including their intensive outpatient and methadone maintenance programs. All incidents involved were categorized as self-inflicted harm. These incidents were further categorized as follows: six (6) were identified as moderate risks and three (3) as minimal risks.
Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

Goal 4: Establish and maintain CT BHP-specific policies and procedures (P&Ps) in compliance with contractual obligations that govern all aspects of CT BHP operations (Contract reference: D.9 and P.2)

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

ValueOptions CT assumes National ValueOptions Policy and Procedures except in cases where they are needed to meet contractual requirements. There were no policy and procedure revisions completed during 2013.

A full review of current CT specific Policy and Produces will be completed in 2014. Changes will be made based on updated contract language or if a national policy and procedure can be used as a replacement to a CT specific policy and procedure.

Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

Goal 5: Establish and maintain a training program that includes compliance with state regulatory requirements and HIPAA regulations and QM functions (Contract reference: V.1 and V.3)

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. Staff training on state regulatory requirements

Staff training on federal and state regulatory requirements is conducted with our new employees during new hire orientation and periodically throughout the year in departmental staff and ad-hoc meetings. The Compliance Department completed 28 face to face training sessions and sent 13 electronic training alerts to staff in 2013. During the month of May the engagement center participated in Corporate Compliance and Ethics Week. Daily activities were designed to highlight the importance of compliance and ethics in the workplace.

B. Staff training on HIPAA/HITECH/42 CFR privacy regulations

The CT Engagement Center staff completed the annual companywide 2013 HIPAA training. ValueOptions National Human Resources Department monitored the process to ensure full compliance with this requirement. Refresher trainings on basic information about PHI, what constitutes a HIPAA violation and how to report a HIPAA violation were conducted over the course of the year.
During 2013, there were 8 audits conducted of the engagement center staff to ensure compliance with the rules around protecting PHI.

A review was completed in 2013 of all documents currently being mailed to our members. Each document containing PHI was reviewed specifically to determine if the PHI was needed. In the documents the PHI was not necessary it was removed to reduce risk to the member.
Additionally, an internal process was implemented requiring all documents containing PHI be reviewed by a member of Senior Management prior to mailing to verify the member information in the letter matches the address on the envelope.

The local and national compliance staff continues to monitor all violations closely. Each violation reported during 2013 was thoroughly investigated and placed into one of the categories listed below.

There was 1 privacy breach and a total 80 policy and regulatory (privacy) violations in 2013. The 80 policy and regulatory (privacy) violations equate to .0013% of the 62,302 authorizations issued during 2013.

- **One (1) – Breach**
  - One (1) – Letter containing PHI was sent to an unintended member; notification to client was completed on March 19, 2013; notification was sent to member via certified mail on May 6, 2013.

- **Forty (40) – Policy Violations:**
  - Thirty (30) - Instances of incorrect information being entered into a member’s record set; there was no disclosure of PHI.
  - Five (5) - Emails sent unencrypted to the intended party (Low risk as email went to intended party).
  - Three (3) – Authorizations were created for the wrong provider; an authorization letter was not generated.
  - One (1) Authorization was created for the wrong member; an authorization letter was not generated.
  - One (1) – Caller was not verified as required by VO policy and procedure; no PHI was disclosed.

- **Forty (40) – Privacy (Regulatory) Violations:**
  - Twenty Seven (27) - Authorizations were created for the wrong provider by Clinical Department or Central Night Service and an authorization letter was generated.
  - Five (5) – Emails were sent encrypted to the wrong provider. (Low risk as email was sent encrypted and provider is required to adhere to HIPAA requirements.
  - Three (3) – Authorizations were created for the wrong member and an authorization letter was generated.
  - Two (2) – Letter sent to an unintended provider (Low risk the provider is required to adhere to HIPAA requirements.)
  - Two (2) – Instances of incorrect information being entered into documented under the wrong provider
  - One (1) – Voicemail was left for the wrong provider (Low risk the provider is required to adhere to the HIPAA requirements)

C. **Staff training on Denials and Appeals**

Clinical staff trainings were conducted several times over the course of 2013 in order to review the medical necessity denial process. Workflows were reviewed and specific questions were answered. The providers’ rights to a doctor-to-doctor conversation (peer to peer review) prior to a determination of a denial was reiterated and further explained so that care managers could inform providers better of their rights both during the peer review process as well as with the
appeal process. The partial denial process was also reviewed as well as appropriate
documentation for when providers are in full agreement with modified requests. In addition,
denials and appeals data was shared in the Geo Teams so that provider trends could be
discussed and support to providers could be given as needed.

D. **Staff training on Complaints**

Trainings with all departments that interface with members, providers and our state partners
occurred several times over the course of 2013. Staff members were reminded how to identify
complaints and what clarifying questions needed to be asked in order to clearly understand the
concern(s). The documentation process of a complaint within the system was also reviewed
during each training session in attempts to improve the reporting.

**Recommendations for continuing goal in 2014:**
This goal continues to be applicable for 2014 but should be expanded in the 2014 project plan
to include additional trainings that are being conducted at VO by the VO-Academy and training
that the Peers participate in annually.

**Goal 6: Ensure timely telephone assess to CT BHP (Contract Reference Q.3 and Q.4)**

**Description of activities and findings that include trending and analysis of the measures
to assess performance over time:**

**Total Volume of Calls**

<table>
<thead>
<tr>
<th></th>
<th>CY 2010</th>
<th>CY 2011</th>
<th>CY 2012</th>
<th>CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>70,410</td>
<td>116,258</td>
<td>130,457</td>
<td>123,979</td>
</tr>
<tr>
<td><strong>Crisis</strong></td>
<td>311</td>
<td>2,982</td>
<td>2,566</td>
<td>3,064</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>32,068</td>
<td>24,800</td>
<td>27,012</td>
<td>26,889</td>
</tr>
<tr>
<td><strong>Provider</strong></td>
<td>38,381</td>
<td>88,386</td>
<td>100,879</td>
<td>94,026</td>
</tr>
</tbody>
</table>

There was a 5.0% decrease in the total volume of call between CY ’12 and CY ’13. Although
crisis calls increased by 19.4%, both non-crisis member and provider calls decreased by 0.5%
and 6.8%, respectively.
A. **Average speed to answer:** Average number of seconds until call is answered by a live person

<table>
<thead>
<tr>
<th></th>
<th>CY 2010</th>
<th>CY 2011</th>
<th>CY 2012</th>
<th>CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis</td>
<td>0:00:03</td>
<td>0:00:05</td>
<td>0:00:04</td>
<td>0:00:03</td>
</tr>
<tr>
<td>Member</td>
<td>0:00:05</td>
<td>0:00:03</td>
<td>0:00:03</td>
<td>0:00:06</td>
</tr>
<tr>
<td>Provider</td>
<td>0:00:06</td>
<td>0:00:04</td>
<td>0:00:05</td>
<td>0:00:06</td>
</tr>
<tr>
<td>Avg. All Calls</td>
<td>0:00:06</td>
<td>0:00:04</td>
<td>0:00:04</td>
<td>0:00:06</td>
</tr>
</tbody>
</table>

There have been minimal changes in the average speed of answer year over year. Performance standards continue to be met.

B. **Abandonment Rate:** Percentage of calls not answered before caller hangs up

<table>
<thead>
<tr>
<th></th>
<th>CY 2010</th>
<th>CY 2011</th>
<th>CY 2012</th>
<th>CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>41</td>
<td>0.06%</td>
<td>0.27%</td>
<td>0.11%</td>
<td>0.18%</td>
</tr>
<tr>
<td>317</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>137</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>227</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The volume of abandoned calls increased by 65.7% between CY ’12 and CY ’13, which was largely due to staffing changes that occurred in the customer service department. As the staff became more seasoned over the course of the year, the rate of abandoned calls decreased.
C – D. Percentage of calls placed on hold and average length of time on hold for Clinical, Customer Service and Crisis Calls

The percentage of calls placed on hold remains consistent for crisis and member calls between 2012 and 2013. The percentage of provider calls decreased slightly from last year.

<table>
<thead>
<tr>
<th></th>
<th>CY 2010</th>
<th>CY 2011</th>
<th>CY 2012</th>
<th>CY 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis</td>
<td>11.26%</td>
<td>8.26%</td>
<td>3.70%</td>
<td>3.25%</td>
</tr>
<tr>
<td>Members</td>
<td>51.29%</td>
<td>45.62%</td>
<td>43.11%</td>
<td>43.25%</td>
</tr>
<tr>
<td>Providers</td>
<td>56.13%</td>
<td>70.17%</td>
<td>71.26%</td>
<td>68.49%</td>
</tr>
</tbody>
</table>

The average hold time for crisis calls continues to decrease in 2013 since reaching a high of 52 seconds in 2011. Stable staffing has assisted in this measure as well as staff trainings on how to manage and crisis call and frequent reminders in clinical staff meeting. The average hold time for provider and member calls increased due to staffing changes in customer service department where fewer representatives were available to manage the call volume.
E. Average Length of Time on Call

The average length of a call in 2013 was 3:09 with provider calls being shorter than the average at 2:48 and member calls being slightly longer at 4:18. This is consistent with previous years. This measure captures the length of the call with the customer service representative and does reflect the full experience of a provider calling into complete authorizations, particularly multiple authorizations. It is recommended that this sub-goal be sunset in 2014.

Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

Goal 7: Develop and implement Quality Improvement Activities (QIA) and initiatives to address opportunities for improvement (Contract reference M.6)

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. Adult Study: IOP

Following the submission of the Performance Target on IOP for 2012, the review of the findings determined that additional analysis of member-level IOP data be conducted. Conducting the member-level analysis would allow us to follow the member over time, examine the incidence of use of multiple providers, breaks in treatment, incidence of inpatient stays and use of other services. The new study period would run from 7/1/11 to 12/31/12. Any member with IOP services during that timeframe would be included, not just those who were admitted and/or discharged. The earlier project had made it clear that a significant portion of the use of this service did not fall neatly into a clear beginning and end of an episode.

By the end of June, 2013, the IOP cohort was identified. The cohort was forwarded to DMHAS in order to obtain the DMHAS data associated with those members. The DMHAS data as received on October 22, 2013. No further activity occurred on this clinical study as all resources were dedicated to finalizing the 2013 performance targets.

B. Child/Adult Study: ED

As part of the 2013 Inpatient Performance Target, use of EDs for both behavioral health and medical services was examined for the years 2011 and 2012. Population characteristics of ED users were compared to the population characteristics of non-users of the ED who had used other behavioral health services, and frequent users of the ED (3 or more ED visits in 2 years) were compared to infrequent users of the ED (1-2 visits within 2 years). Additionally, regressions were completed to identify a profile of 1) members who use the ED, 2) members who utilize the ED 3+ times, and 3) member level and service level predictors of members who will be readmitted to the ED within 180 days. Finally, comparisons of ED volume and admission rates were made across all in-state EDs. Comparisons of the admit rates of urban, suburban, and rural, high, moderate and low volume, and teaching/non-teaching affiliated EDs were made. All of the analyses and comparisons were broken out by youth and adults.
### Adults: Age Group by Diagnosis Indicator

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Behavioral Health Primary</th>
<th>Primary Med/Secondary BH</th>
<th>Medical Only</th>
<th>Total # of Episodes</th>
<th>% Total in ED Episodes</th>
<th>% Total in Adult Medicaid Pop</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of ED Visits</td>
<td>% of Total</td>
<td># of ED Visits</td>
<td>% of Total</td>
<td># of ED Visits</td>
<td>% of Total</td>
</tr>
<tr>
<td>18 - 25</td>
<td>11,648</td>
<td>14.78%</td>
<td>18,371</td>
<td>16.34%</td>
<td>132,147</td>
<td>20.78%</td>
</tr>
<tr>
<td>26 - 34</td>
<td>17,592</td>
<td>22.32%</td>
<td>30,847</td>
<td>27.43%</td>
<td>172,107</td>
<td>27.07%</td>
</tr>
<tr>
<td>35 - 44</td>
<td>16,591</td>
<td>21.05%</td>
<td>26,420</td>
<td>23.50%</td>
<td>141,104</td>
<td>22.19%</td>
</tr>
<tr>
<td>45 - 54</td>
<td>23,191</td>
<td>29.42%</td>
<td>26,238</td>
<td>23.33%</td>
<td>122,626</td>
<td>19.28%</td>
</tr>
<tr>
<td>55 - 64</td>
<td>9,165</td>
<td>11.63%</td>
<td>9,628</td>
<td>8.56%</td>
<td>57,953</td>
<td>9.11%</td>
</tr>
<tr>
<td>65 +</td>
<td>643</td>
<td>0.82%</td>
<td>941</td>
<td>0.84%</td>
<td>9,929</td>
<td>1.56%</td>
</tr>
<tr>
<td>Total</td>
<td>78,830</td>
<td>9.5%</td>
<td>112,445</td>
<td>13.6%</td>
<td>635,866</td>
<td>76.9%</td>
</tr>
</tbody>
</table>

Note: Behavioral Health category includes all ED visits that had a primary behavioral health diagnosis on the corresponding ED Claim

There were a total of 827,141 ED visits by adults included in this study. Of those ED visits, 9.5% were associated with a primary behavioral health diagnosis, 13.6% with a primary medical and secondary behavioral health diagnosis, and 76.9% with only medical diagnoses. If we assume that individuals who enter the ED with a medical diagnosis and are then determined to also have a behavioral health diagnosis are included in the second category and we sum the individuals in the first two categories, we find that nearly 25% of individuals using the ED have behavioral health diagnoses.

For the adult population, there were remarkably few disparities between the Medicaid population as a whole and the ED utilizers with a primary medical complaint. The disparity in use of behavioral health-related ED services was greatest for the 45-54 year olds. This population was greatly over-represented in the behavioral health primary category of ED visit and over-represented to a lesser extent in the primary medical/secondary behavioral health category.

### Youth ED Visits with Diagnosis and Age Group

<table>
<thead>
<tr>
<th>Age</th>
<th>Behavioral Health Primary</th>
<th>Primary Med/Secondary BH</th>
<th>Medical Only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td># of ED Visits</td>
<td>% of Total</td>
<td># of ED Visits</td>
</tr>
<tr>
<td>3 - 12</td>
<td>3,154</td>
<td>24.67%</td>
<td>3,140</td>
</tr>
<tr>
<td>13 - 17</td>
<td>9,629</td>
<td>75.33%</td>
<td>5,174</td>
</tr>
<tr>
<td>Total</td>
<td>12,783</td>
<td>4.2%</td>
<td>8,314</td>
</tr>
</tbody>
</table>

There were a total of 304,686 ED visits by youth during the two year study period. Based on the diagnoses associated with those ED visits, 93.1% were associated with medical issues, 4.2% with primary behavioral health issues and 2.7% with primary medical/secondary behavioral health issues.
Adolescents, who make up only 34% of the youth Medicaid population, are overly represented in the behavioral health-related categories. Children are under-represented in the behavioral health-related categories and slightly over-represented in the medical only category.

Population Characteristics of ED utilizers compared to non-ED utilizers of other behavioral health services

The following analyses focus on the unique members who utilized ED services during the study period.

<table>
<thead>
<tr>
<th>Adult Medicaid Population: Behavioral Health Cohort</th>
<th>ED Utilizers</th>
<th>Non-ED Utilizers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Indicator</td>
<td># of Members</td>
<td>% of Total</td>
</tr>
<tr>
<td>Total N's for Utilizer Groups</td>
<td>n=73,147</td>
<td>n=104,401</td>
</tr>
<tr>
<td>Mental Health</td>
<td>54,104</td>
<td>73.97%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>41,296</td>
<td>56.46%</td>
</tr>
<tr>
<td>Co-Occurring (Med &amp; BH)</td>
<td>27,255</td>
<td>37.26%</td>
</tr>
</tbody>
</table>

Adults who utilized the ED for behavioral health reasons were only slightly more likely to have had a mental health diagnosis at some point during the study period than were adults who did not use the ED. However, adults who used the ED were more likely to have been diagnosed with a substance abuse problem as well as a co-occurring medical problem than were adults who did not use the ED.

<table>
<thead>
<tr>
<th>Youth Medicaid Population: Behavioral Health Cohort</th>
<th>ED Utilizers</th>
<th>Non-ED Utilizers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis Indicator</td>
<td># of Members</td>
<td>% of Total</td>
</tr>
<tr>
<td>Total N's for ED Utilizer Groups</td>
<td>n=11,106</td>
<td>n=52,013</td>
</tr>
<tr>
<td>Mental Health</td>
<td>10,579</td>
<td>95.25%</td>
</tr>
<tr>
<td>Substance Abuse</td>
<td>2,922</td>
<td>26.31%</td>
</tr>
<tr>
<td>Co-Occurring (Med &amp; BH)</td>
<td>3,769</td>
<td>33.94%</td>
</tr>
</tbody>
</table>

Medicaid youth who utilized the ED during the study period were diagnosed with substance abuse and with co-occurring medical disorders more frequently than were youth who received behavioral health services but had not visited the ED. It is hypothesized that substance abuse is under-diagnosed in the youth Medicaid population. High percentages of both populations (>95%) were diagnosed with mental health problems.

Adults who visited the ED for behavioral health reasons were more likely to have been diagnosed with anxiety disorders, attention deficit disorders, mental disorders due to a medical condition, mood disorders, personality disorders, and psychotic disorders than were adults who had received behavioral health treatment but who had not visited the ED.
With the exception of adjustment disorder, youth who had utilized the ED during the study period were more likely to have received any of the 13 categories of behavioral health diagnoses than were youth who had not visited the ED.

Adults who utilized the ED were more likely to have a co-occurring medical diagnosis of Asthma and Chronic Obstructive Pulmonary Disorder than were adults who did not utilize the ED for behavioral health treatment.

Youth who visited the ED were diagnosed with asthma, diabetes and intellectual disabilities at a higher rate than youth who received behavioral health services but who had not visited the ED.

The following population characteristics were found to be associated with over-representation in the use of the ED:

- Males were over-represented among ED utilizers.
- Adults between the ages of 45 and 54 and adolescents were over-represented among ED utilizers.
- HUSKY D adults were greatly over-represented among ED utilizers; HUSKY C adults were moderately over-represented.
- Eligibility categories were not useful in describing the youth population’s use of the ED.
- Caucasians were over-represented among both adult and youth ED utilizers while Asians, Blacks and Hispanics were under-represented.
- DMHAS-involved adults were highly over-represented among ED utilizers as were youth who were DCF-involved.
- Homeless adults were significantly over-represented among ED utilizers.

Finding associated with the regressions:
The first set of regressions included members who utilized the ED and members who utilized behavioral health services but did not utilize the ED. The goal was to identify the characteristics (demographic, utilization, and diagnostic) of members who utilized ED services. The second set of regressions included only those members who utilized the ED and compared those who utilized the ED two or fewer times with those who used the ED three or more times.

**Adult Risk Factors Associated with ED Visits:**

<table>
<thead>
<tr>
<th>Factors</th>
<th>One or More ED Visits</th>
<th>3+ ED Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obs Unit Stays/ Multiple Providers</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Multiple Home Health Providers</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ETOH-Related Disorders</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Developmental Disorders</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Disruptive Behavior Disorders</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorder (non-Schizophrenia)</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
As can be seen in the table above, among adults, several factors were associated with both one or more ED visits as well as with three or more ED visits. Adults with multiple stays in Observation beds associated with more than one hospital were more likely to utilize the ED and to use it frequently. These adults would be visiting multiple EDs, perhaps seeking admission to an inpatient unit. Similarly, adults who received home health services from multiple home health providers were also more likely to utilize the ED and to use it more frequently. In this case, it is likely that the member has had multiple inpatient stays and was referred to different Home Health agencies at the time of discharge from each of those stays. This factor is probably associated with chronicity and lack of coordination of care.

Diagnoses associated with the use of the ED and frequent use of the ED for behavioral services include Developmental Disorders and nicotine use. Several diagnoses, associated with the use of the ED at least once, are not predictors of the use of the ED at higher rates of frequency.

### Youth Risk Factors Associated with ED Visits:

<table>
<thead>
<tr>
<th>Factors</th>
<th>One or More ED Visits</th>
<th>3+ ED Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older Age</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>1+ Inpatient Medical Stays</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>1+ Community Residential Stays</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Hx of PRTF Stay</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Obs Unit Stays/Multiple Providers</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>ETOH-Dx</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Psychotic Disorder (non-Schizophrenia)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Personality Disorder</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
Risk factors that predict both one or more ED visits as well as three or more ED visits by youth included a history of a PRTF stay, and diagnoses of psychoses, substance abuse disorder, and/or personality disorder. Similar to adults, youth with Alcohol use-related disorders and psychoses without a diagnosis of schizophrenia, and youth with multiple stays in Observation beds associated with more than one hospital were more likely to utilize the ED.

A second set of regressions were completed that included only members who had used ED services at least once during the study period. Additionally, these regressions include information regarding the BH services that the member received before and after the index ED visit. The inclusion of this information allowed the assessment of whether the type, timing, and the continuity of BH services influenced whether members were readmitted to the ED.

### Adult Predictors of Readmission to the ED within 30, 60, 90 and 180 days

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>Readmission to ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>X</td>
</tr>
<tr>
<td>Caucasian</td>
<td>X</td>
</tr>
<tr>
<td>Homeless at some point during previous year</td>
<td>X</td>
</tr>
<tr>
<td>DHMAS-Involved</td>
<td>X</td>
</tr>
<tr>
<td>Co-Occurring MH and SA disorders</td>
<td>X</td>
</tr>
<tr>
<td>Intellectual Disabilities</td>
<td>X</td>
</tr>
<tr>
<td>ETOH Use Disorder</td>
<td>X</td>
</tr>
<tr>
<td>Anxiety Disorder</td>
<td>X</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>X</td>
</tr>
<tr>
<td>Nicotine Dependence</td>
<td>X</td>
</tr>
<tr>
<td>Other Drug Use Disorders</td>
<td>X</td>
</tr>
<tr>
<td>Personality Disorders</td>
<td>X</td>
</tr>
<tr>
<td>Psychosis</td>
<td>X</td>
</tr>
<tr>
<td>Delirium Disorders</td>
<td>X</td>
</tr>
<tr>
<td>More days since last BH service</td>
<td>X</td>
</tr>
<tr>
<td>Larger # of ED BH visits within 180 days before index visit</td>
<td>X</td>
</tr>
<tr>
<td>Younger age at index ED visit</td>
<td>X</td>
</tr>
<tr>
<td><strong>AND USE OF THE FOLLOWING BH SERVICES IN THE 180 DAYS PRIOR TO THE INDEX ED VISIT INCREASED THE LIKELIHOOD OF READMISSION:</strong></td>
<td></td>
</tr>
<tr>
<td>DMHAS Detox Days</td>
<td>X</td>
</tr>
<tr>
<td>DMHAS Residential Days</td>
<td>X</td>
</tr>
<tr>
<td>Methadone Maintenance Units used</td>
<td>X</td>
</tr>
<tr>
<td>IOP</td>
<td>X</td>
</tr>
<tr>
<td>PHP</td>
<td>X</td>
</tr>
</tbody>
</table>
The results of the multivariate analysis displayed in the table above, and above the behavioral health services listed, include both member-level characteristics (e.g., gender, race/ethnicity, DCF-involved, primary language, etc.) and episode-level descriptors (e.g., age and diagnosis at the time of the ED visit, services during the 30 days before and after the ED visit, etc.). When predicting episode-level outcomes with a combination of member-level and episode-level characteristics, there are two types of findings: those that involve significant associations for member-level characteristics that predict further ED visits AND findings regarding episode-level descriptors that predict an additional ED visit.

The service variables that were found to be significant predictors of readmission to the ED are included at the bottom of the table. Data regarding the units of particular behavioral health services during the 180 days before the index ED episode were included individually (i.e. one at a time) in the regression models based on member-level characteristics and episode-level descriptors. Most of the service variables were not significantly associated with an ED outcome after controlling for the core list of variables presented above. For each of the behavioral health services in the table above, a larger number of units during the 180 days before the index ED episode were associated with a higher likelihood of an additional ED visit within the 30, 60, 90 and 180 days of the index ED episode.

**Youth Predictors of Readmission to the ED within 30, 60, 90 and 180 days**

<table>
<thead>
<tr>
<th>VARIABLES</th>
<th>Readmission to ED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>X</td>
</tr>
<tr>
<td>Autism Spectrum Disorder</td>
<td>X</td>
</tr>
<tr>
<td>Intellectual Disability</td>
<td>X</td>
</tr>
<tr>
<td>DCF-Involved</td>
<td>X</td>
</tr>
<tr>
<td>Co-Occurring MH and SA disorders</td>
<td>X</td>
</tr>
<tr>
<td>Use of DCF Flex Funds</td>
<td>X</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>X</td>
</tr>
<tr>
<td>Major Depression</td>
<td>X</td>
</tr>
<tr>
<td>Nicotine Dependence</td>
<td>X</td>
</tr>
<tr>
<td>PTSD</td>
<td>X</td>
</tr>
<tr>
<td>Psychosis</td>
<td>X</td>
</tr>
<tr>
<td>Fewer days since last BH service</td>
<td>X</td>
</tr>
<tr>
<td>Larger # of ED BH visits within 180 days</td>
<td>X</td>
</tr>
<tr>
<td>Older age at index ED visit</td>
<td>X</td>
</tr>
<tr>
<td>Larger # of IP days within 180 days before</td>
<td>X</td>
</tr>
<tr>
<td>AND USE OF THE FOLLOWING BH SERVICES IN THE</td>
<td></td>
</tr>
<tr>
<td>180 DAYS PRIOR TO THE INDEX ED VISIT</td>
<td></td>
</tr>
<tr>
<td>INCREASED THE LIKELIHOOD OF READMISSION</td>
<td>X</td>
</tr>
<tr>
<td>Case Management services</td>
<td>X</td>
</tr>
<tr>
<td>EDT</td>
<td>X</td>
</tr>
</tbody>
</table>
The same description of the regressions noted following the adult table above apply to the findings for the youth.

In comparing the findings of the adults and the youth, it is interesting to note the similarities and the dissimilarities. The similarities between adults and youth in predicting readmission to the ED included DMHAS or DCF involvement, Intellectual Disabilities, Psychoses, Bipolar Disorder, and Co-Occurring MH and SA disorders. Larger numbers of IOP and PHP visits during the 180 prior to the index ED visit were associated with readmission to the ED. The dissimilarities included: adult males are at increased risk of readmission to the ED while females are more at risk among youth, adults were more at risk of readmission to the ED with more days since their last behavioral health service while youth were more at risk the fewer the days since their last behavioral health service, and adults were more at risk the younger they were at the index ED visit while youth were more at risk the older they were at the index ED visit.

C. Reducing discharge delays for youth receiving inpatient behavioral health treatment
(Contract reference: 2012 Performance Target 2)

The target related to discharge delay days for this Performance Target was a maintenance measure calculated based on CY2011 discharge delay performance. Per Performance Target 2, the Contractor will maintain discharge delay days at 14% or less of total inpatient days. Specifically, “Pct. of Inpatient Days in delay status for All Members during Qtr” as reported on the 10B Part 7 report (All Members, IPF & IPM, and excluding Solnit Center) shall total no more than 13% in CY 2013 and acute average length of stay shall increase by no more than 3% in CY 2013 from the baseline established during Q3 and Q4 of CY 2011 of 11.34 days.

The EOY results of Performance Target 2 is computed via the attached 10B_7 Census Analysis Report-Discharge Delays by Service Class and the IPF Length of Stay Analysis (CTBH08076).

<table>
<thead>
<tr>
<th></th>
<th>2013</th>
<th>Annual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Delay %</td>
<td>8.44%</td>
<td></td>
</tr>
<tr>
<td>Acute Average Length of Stay Days</td>
<td>11.38</td>
<td></td>
</tr>
</tbody>
</table>

To meet the established target of no greater than 13% of total inpatient days, we maintained the operational and collaborative efforts that were implemented for CY 12 into CY 13 with continued success. A deeper collaboration with DCF area offices evidenced by the continued deployment of our Child ICM staff to the local DCF Regional Offices proved instrumental in our overall success. The ability to maintain the discharge delay percentage of days below the 13% mark was largely due to the focused efforts among CT BHP, DCF and the provider network.
The percent of days delayed continues to decrease year after year with 2013 experiencing the lowest percentage to date at 8.4%. In addition, the number of youth delayed continues to decrease as well.

**Recommendations for continuing sub-goal in 2014:**
This goal will be modified to reflect the clinical studies that have been agreed upon with the State partners for the 2014 project plan. The 2014 study associated with ED use will focus on the adult population. Super-utilizers of the ED will be defined and identified and a clinical intervention will be designed to reduce the use of the ED by frequent utilizers. Additionally, a methodology for evaluating the rates of primary care and behavioral health providers by frequent users of the ED will be developed.


Description of activities and findings that include trending and analysis of the measures to assess performance over time:

**A. Assess individual Customer Service staff (at least 5 cases per month) on performance in five (5) areas**

During 2013, The ValueOptions NICE system was utilized to conduct auditing of the Customer Service Staff. The Customer Service Supervisor conducted audits. The audit average for the department was 97.9% for 2013. Customer service staff received feedback regarding their individual performance during 1:1 supervision and the Customer service team received feedback regarding overall department performance during staff meetings.

**B. Assess adequacy and accuracy of documentation of content of call.**

The Customer Service Department conducts audits of the accuracy of the documentation that results from calls into the department. Audit results indicate that with the exception of misdirected calls (medical, dental or vision) Customer Service staff routinely document every call received. Based on results from the NICE system, the scores for documentation were above the goal of 90%. Actual results for 2013 were 98.6%. The audits identified opportunities
for improvement in the quality of the documentation in member records regarding the content of the call. This finding was followed up on during individual supervision, weekly staff meetings, and trainings.

The opportunity for improvement around professional etiquette and tone was also identified during the audit process. During 2013, 50% of the Customer Service staff members were newly hired. The seasoned staff members were able to provide hands on training to the new hires in regards to telephone etiquette and feedback was provided during individual supervision and weekly staff meetings. In addition to that training, all new staff completed the Comprehensive CT Call Center training, including system application, telephone etiquette and call handling, resource development, and process & procedural work flows.

**Recommendations for continuing goal in 2014:**
This goal continues to be applicable for 2014 and should be included in the 2014 project plan.

**Goal 9: Review and approve the 2013 Utilization Management (UM) Program Description (Contract reference: F.3)**

**Description of activities and findings that include trending and analysis of the measures to assess performance over time:**

The 2013 UM Program Description was submitted to the State clients for approval on April 1, 2013. The UM Program Description and Appendix F – The ICM program description were resubmitted following discussion with the Departments and revisions on June 3, 2013. Formal approval of the documents by the Departments was received on June 6, 2013.

**Recommendations for continuing goal in 2014:**
This goal continues to be applicable for 2014 but will be included in goal 1 as sub-goal D in the 2014 Project Plan.

**Goal 10: Ensure Utilization/Care Management department compliance with established UM standards (Contract reference: F.13)**

**Description of activities and findings that include trending and analysis of the measures to assess performance over time:**

A. Clinical training plan is complete as defined in program description

All new ValueOptions staff participates in general new hire orientation. The clinical department maintains a new hire checklist approved by the State to monitor trainings and training needs of staff. Continuing education to clinical staff is provided by the clinical department on a weekly basis, in addition to ValueOptions Academy trainings provided to the engagement center. Documentation of training is retained in Human Resource files of all clinical staff. CT BHP maintains a training site within a shared documents site which all employees have access to.
Use the Calendar list to keep informed of upcoming meetings, deadlines, and other important events.

<table>
<thead>
<tr>
<th></th>
<th>April, 2014</th>
<th>Expand All</th>
<th>Collapse All</th>
<th>Day</th>
<th>Week</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td></td>
<td></td>
<td></td>
<td>30</td>
<td>31</td>
<td>1</td>
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<td></td>
<td>2</td>
<td>3</td>
<td>4</td>
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<td></td>
<td></td>
<td>26</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **10:00 AM** Peer Department Overview
- **9:00 AM** Service & Care Connect New Hire Training (SCC)
- **11:00 AM** Data Management and Analytics with Sue Donovan
- **11:30 AM** RNM Overview
- **2:30 PM** Clinical Liason Overview
- **10:00 AM** Community Health Network (CHN) ICM Program Overview
- **2:00 PM** Quality Management Department Overview with Diane DiCenzo
- **11:30 AM** Home Health Dept Overview
- **10:00 AM** Project
- **2:30 PM** Customer
- **1:00 PM** Provider
B. Clinical staff utilize current, accurate information to manage contract

Clinical staff is trained on all contract requirements including ongoing new and revised information and requirements. Established meetings serve as a forum to communicate this information to all staff. Meetings include: Monthly compliance meeting to review contract requirements with management, Call center and Interface meetings to communicate information to all Clinical liaisons, Peer staff and Customer service staff, Weekly Clinical department meetings, in addition to Geo team meetings and departmental meetings. A weekly Utilization Management committee meeting reviews changes to UM standards and establishes operational processes to implement contract requirements, including new and revised contract information.

Recommendations for continuing sub-Goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

Goal 11: Monitor compliance with individual standards for ICM caseload expectations

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. Review data for ICM consumers and program services utilized

For those members who are not connected to the service delivery system, ICM efforts focus on identifying and connecting the member to the appropriate provider(s), and may also include a referral to our Peer Support Team, Advanced Behavioral Health (ABH) case management and/or the LMHA to help identify community based resources to facilitate a positive outcome. Referrals to ABH and Peer Services are tracked monthly and reviewed for accuracy. For active cases, ICMs and Clinical Managers continuously view internal census reports to understand
utilization patterns across levels of care, monitor ALOS, and to improve care coordination with providers.

B. Review ICM admission criteria

Referral Criteria – ValueOptions Clinical Leadership, in partnership with the State partner agencies, have developed referral criteria for the CT Engagement Center ICM Program based on capacity and contract-specific requirements. The contract managers of the partner agencies work with ValueOptions Clinical Leadership to determine how to maximize resources and prioritize referrals within the standard criteria. ICM referral criteria is based on utilization of services or factors which present as a barrier to treatment or clinical services to the member in four key areas; acute psychiatric care services, treatment engagement, clinical risk, and other factors which may put member at clinical risk.

Triage - The referral is pre-screened by the Intensive Care Management team or other designated triage staff to evaluate appropriateness for the program. Once these factors are evaluated, further stratification can occur through use of the ICM module Assessment tool in Care Connect system. Information considered in the pre-screen includes:

- Case documentation in the UM or medical management system
- Program criteria qualifications
- Coordination with medical and behavioral Care Managers or providers familiar with the needs of the individual
- Level of risk based upon history and current clinical data

ICM staff then review member history and current acuity to develop acuity stratification/tier based on the 16 categories outlined below in the Care Connect ICM module. The ICM acuity is then scored and the level of tiered intervention is assigned.

Low ICM Intensity At-Risk defined by:

- Members being referred from Inpatient facility to PRTF, RCT, GH, Riverview or CVH hospital or other State inpatient admission
- Those members requiring coordination of care due to demonstrated, documented and consistent non-engagement with community-based services for a period of at least 6 months, placing member at risk for psychiatric or substance abuse hospitalization
- Adolescents aging out of DCF or special education services who are diagnosed with a psychiatric condition and who are encountering barriers to care.
- Those members discharging from a long term placement or state facility who are in need of coordination of care

Moderate and High ICM intensity; At-Risk defined by:

In order to be considered for admission to the most intensive levels of ICM care management (Tier 2 and Tier 3), at a minimum an individual must meet each of the three following criteria:
1. Demonstrate behavioral symptoms consistent with a DSM-IV-TR (Axes I-V) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention

2. Require assistance in obtaining and coordinating treatment, rehabilitation, and social services

3. Member must be identified with a high risk status (defined as a likelihood of self-injury, death, inability to care for self, need of hospitalization to ensure safety, and/or prevent harm to others). The clinical and quality leadership, in discussion with State partners, will determine which factor(s) will be prioritized for program participation based on contractual requirements, program capacity, and population patterns. Examples of factors indicating high risk might include, but not be limited to, any of the following:

a. **Multiple IP admissions** - More than four inpatient admission within the past six months for primary behavioral health issues or co-morbid behavioral/medical health conditions, and no evidence of ongoing treatment support following the IP discharge to resolve issues precipitating the need for acute care.

b. **Multiple ED admissions** - More than four (4) Emergency Department visits with psychiatric complaints in the past six months and no evidence of ongoing treatment support within the last 60 days following the last ED discharge to resolve issues precipitating the need for emergency care.

c. **Complex co-morbid behavioral and medical health** conditions, including, but not limited to, diabetes, heart disease, obesity, HIV, pregnancy, at risk for or diagnosed with postpartum depression, or psychosis, requiring significant coordination between behavioral and medical treatment providers.

d. **Significant suicidal or homicidal risk** - Recent history (within the past six months) of serious, life threatening attempts requiring medical treatment, and for which Intensive Care Management is indicated to ensure ongoing treatment support and promote patient safety.

e. **Multiple failed Substance Abuse treatment attempts** - as evidenced by 2 or more failures to follow-up with referrals or discontinued treatment Against Medical Advice (AMA).

f. **Failed out-of-home placement(s)** or significant disruption of a foster placement during the last six months.

g. **Discharge from a long-term placement or state facility**

h. **Repeated high risk behaviors** - Determination of repeated high risk behaviors (as evidenced by a likelihood of self-injury, death, inability to care for self, hospitalization, and/or prevent harm to others) including, but not limited to, running away from treatment facilities, repeated non-compliance with treatment or medications, engaging in repeated self-injurious behaviors, or involvement with protective services agencies.

i. **Member of Special vulnerable population group** (with no evidence of ongoing treatment support to resolve potential issues associated with their condition):
   i. Pregnant women with substance abuse disorders
   ii. Children 5 yrs. old or younger with Bipolar diagnosis
   iii. Children 10 yrs. old or younger with IP admit
iv. Special Needs Population (SNP) such as Autism spectrum diagnosis with PDD as a contributing factor; Child or adolescent whose parent has a history of a SA/MH issue and who needs assistance with child-care needs

v. Young Adult aging out of or transitioning to new state agency

j. Complex psychiatric cases including those with multiple state/provider agency involvement requiring coordination of care between specialty providers (ex: eating disorder cases requiring coordination between individual and providers); multiple family members using BH or state services.

k. Diagnostic Specialty Unit referrals such as Eating Disorder, Dual Diagnosis – MH & SA, Complex Child and Adolescent cases, Other special needs as identified.

Medical Care Coordination/ Integrated Care

Members with health issues and possible behavioral health concerns are referred for screening and service coordination as needed. These referrals will typically be managed in Tier One, lower intensity outreach with screening, resource coordination, and follow-ups. Upon screening, members may be transitioned to higher intensity participation in the ICM program.

Engagement

If the member meets program criteria and is considered to be an appropriate candidate for the ICM program, the ICM

- Contacts the providers who are actively involved with treatment, as appropriate, and elicits their participation.
- Flags the case in the system with the “ICM” flag and secondary “reason for inclusion” flags and assigns an ICM Care Manager (CM)
- Contacts the member, as appropriate to introduce the program

Care Planning and Progress Monitoring

After completing the assessment, the ICM Care Manager, collaborates with the member and care planning team to create an individualized, member-centric Focal Treatment Plan (FTP) for care/recovery. The FTP identifies short and long term goals, objectives and time frames to meet the member’s clinical needs. Elements of this documentation include:

- **Priority Goal**
  - Identification of priority goal is established. This may be covered in blow goals/objectives. Use process to facilitate a **Specific** outcome, **Measureable** results, **Attainable**, **Realistic**, and within a specified **Timeframe** (SMART). Record member’s priority goal and track progress.

- **Safety**
  - Provider reports safety and stability, not in crisis. Immediate safety assured via coordination with appropriate level of care treatment options including: emergent/urgent service providers; hospital evaluation; higher levels of care programs; outpatient providers
Following resolution of crisis event, member has safety plan – who to contact, early warning signs, ongoing treatment, self-care strategies to prevent recurrence of crisis events

Member has continued access to care following inpatient event

- **Treatment Participation – Per provider**
  - Member has appropriate referrals/connection to outpatient providers and barriers to access have been addressed
  - Based on member preference, member has access to reasonable outpatient medication options and participates in treatment
  - Based on deterioration of functioning, member has access to higher level of care options and participates in treatment
  - Based on improvement of functioning, member has access to reasonable outpatient options and participates in treatment
  - Based on member preference, member has access to appropriate community options and participates in programs/services

C. Review discharge criteria

**Discharge Criteria:**

To fully assess discharge readiness the ICM consults the treating providers. The member's current status may be reviewed in multidisciplinary rounds to help inform case closure. A post program plan is developed to confirm resources which will be used for continued care and how to contact the ICM program if a significant change indicates the need for re-involvement.

When the member meets discharge criteria and a post-discharge plan has been developed and agreed to by multidisciplinary team, the ICM discharges the member from active status in the ICM program and closes out the case in the UM system by indicating a case expiration date.

Typical reasons for case closure/discharge criteria include:

- Member is assessed to be **safely engaged** in ongoing treatment. The identified barriers to treatment have been resolved and the member is able to participate in and benefit from more standard treatment and management programs without the need for the intensity and support of the ICM program.
- The member has **returned to functional or symptomatic baseline** and there is no reasonable expectation of further improvement and no longer requires ICM.
- ICM goals have been met or services have been discontinued by the provider(s) because the **member no longer requires those services**.
- Member/family **declines to accept** the proposed treatment plan or a viable alternative or is unwilling or unable to participate in the treatment plan or follow appropriate recommendations.
- Member enters long term **residential or custodial** care.
- Member is **no longer eligible** for Medicaid covered services. (Appropriate transition/coordination of care will be provided by VO to ensure connection with new insurer).
• Ongoing CM services from another resource such as the Health Plan Care Manager or Disease Management Program are better positioned to address the member’s primary needs. VO’s ICM may continue involvement as a secondary consultant, as needed.
• The multidisciplinary team agrees that the member is ready for discharge from the ICM program or that the intended degree of stability has been reached.
• Member is not responsive to outreach attempts, supports or referrals.

D. Review high utilizers report

There are two reports that track high utilization. The first is the high utilizer report which includes all Medicaid members who have been admitted to 4 higher levels of care (IPF, IPM, IPD, and PRTF) in the past 6 months. The second report is specific to members who use Inpatient detox at high rates. This IPD high utilizer report is used to assign ICM and Peer Support on a weekly basis.

E. Identify monitors to assess the success of the ICM program, including pilot programs

In 2013, the Adult ICM study included data collection for 6 months pre- and post-ICM assignment in an effort to understand if ICM services are effective and/or impactful. Adult members did spend less time in confined settings post their ICM assignment compared to prior to their ICM assignment. This was true for both the inpatient facilities and the inpatient detox facilities. The time in community data suggests that ICMs were successful in facilitating access to care for the assigned high-risk adult Medicaid members, thereby reducing time spent in confined settings.

The St Francis Pilot was conducted throughout 2013. Preliminary data were collected in September when pilot interventions were still occurring and again in March, after the pilot had been completed. The preliminary data suggested that readmission rates were higher for Pilot members than overall St. Francis rates, and higher than statewide averages. However, Pilot members did spend more time in the community and less time on inpatient units post index episode. Data for the entire duration of the Pilot is currently being aggregated and interpreted.

F. Review elements and services that may be impacting discharge delay

The inpatient percent of days delayed for this year was the lowest annual percent recorded. The percentage of DCF children in delay has continued to decrease over the past year, while the Non-DCF percentage has increased. The decrease in delay for the DCF population is the primary driver of the overall decrease seen this year and is the lowest recorded for this population. The overall number of children in discharge delay has also decreased over the past year by 9%. The Non-DCF population comprised 55% of the annual cases delayed, and DCF the remaining 45%.

The greatest percent of discharge delay for the year and the current quarter were those children awaiting PRTF level of care. This year we have seen consistent quarterly increases in the average days in delay for those children awaiting PRTF. The population awaiting community PRTF level of care are those children who are ages twelve and under. We have seen a 36% increase in the number of cases (59 to 80) in delay awaiting PRTF level of care this year, as well as an overall increase in PRTF referrals.
Subsequently, clinical service availability for children 12 years old and younger remains a particular concern. Due to State mandates, DCF and hospitals are no longer requesting residential or Solnit placement, but instead are more frequently seeking PRTF. While the discharge delay days and volume of children awaiting the State hospital and Residential placement has decreased over the past year, the volume and the time in discharge delay awaiting PRTF has increased.

ValueOptions continues to collaborate with inpatient providers and State agencies to address the barriers and the gaps in the service delivery system that contribute to discharge delay at various levels of care, including hospital emergency departments. The Rapid Response system utilized at CCMC to address high volume and delays in the emergency departments has continued. The goal is to support connection to the right clinical services in a timely manner and prevent unnecessary hospitalizations. The program also assists in building a diversion system that can then follow the youth post discharge from the ED within the community. It is the goal in the upcoming quarters to expand this model to other high volume emergency departments.

Intensive Care Managers have continued to work with DCF on site, including the inpatient units, as well as on site at Solnit Center inpatient unit. The Intensive Care Managers have implemented weekly triage meetings with the Solnit PRTF units (South and North), and the community PRTFs to discuss admissions, case management, discharge planning, and identifying those youth who may be at risk for discharge delay. The Family Peer Specialists have continued to work in collaboration with DCF and the FAVOR Family System Managers to build collaborative networks within their regions to support families. The Family Peers have an increased focus on connecting and supporting the member to care post discharge from an ED or an inpatient unit while supporting crisis planning and education to families. They have continued this process through case management and the Connect to Care process.

In addition, the Congregate Care Network Managers have continued to collaborate with assigned DCF area offices and the Systems Managers within the DCF Regions to improve care coordination and program management processes that will ultimately assist DCF in managing the clinical needs of CT’s youth.

Recommendations for continuing sub-goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

Goal 12: Monitor for under or over-utilization of behavioral health services; identify barriers and opportunities

Description of activities and findings that include trending and analysis of the measures to assess performance over time:
Youth Membership:

Total youth membership has increased 20% from 2008 to 2013 with consistent annual increases over the past six calendar years, and a 0.8% increase (330,902 to 333,441) over the last year. Annual increases in youth membership are a trend that has been consistent over the past several calendar years (beginning with CY ‘08).

Over the past two years, there has been a 19% decline (15,321 to 12,427) in DCF youth membership, with an 11% decline (13,964 to 12,427) occurring over the last year.
Overall, there has been an upward trend in Non-DCF membership since 2011. Non-DCF membership increased 3.6% (317,977 to 329,348) over the past two years, with a 1% increase (326,003 to 329,348) over the last year. There have been consistent annual increases in Non-DCF membership.

Adult Membership:

Due to anticipated updates in the membership for the final quarter of 2013, analysis of the annual adult membership will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.

A. Inpatient Psychiatric Hospitalization

Youth Inpatient Psychiatric Hospitalization

Inpatient Admits/1,000 for all youth (0-17) increased 10% (0.70 to 0.77) from calendar year 2012 to 2013. The Non-DCF Admits/1,000 accounted for the majority of this yearly increase,
increasing by 13.7% (0.51 to 0.58), compared to the DCF Admits/1,000 which did not change (0.19 to 0.19). The Non-DCF population comprised 75% (N= 2,025) of the total volume of admissions this year (N=2,701), compared to 25% of the DCF admissions (N=676). There has been a consistent yearly increase in the Non-DCF Admits/1,000 since 2008. Over the same period, the DCF Admits/1,000 yearly rates have steadily decreased. This suggests the increase in Total membership has contributed to the overall increased admissions, specifically the Non-DCF population. Additionally, there was a statistically significant increase (12.7%) in inpatient Admits/1,000 from Q4 ’12 to Q4 ’13.

<table>
<thead>
<tr>
<th>Year</th>
<th>Total</th>
<th>DCF</th>
<th>Non-DCF</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>12.78</td>
<td>7.86</td>
<td>4.92</td>
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<td>2009</td>
<td>10.48</td>
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<tr>
<td>2010</td>
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<td>2011</td>
<td>9.05</td>
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<td>5.26</td>
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<tr>
<td>2012</td>
<td>9.12</td>
<td>3.45</td>
<td>5.67</td>
</tr>
<tr>
<td>2013</td>
<td>9.70</td>
<td>2.98</td>
<td>6.73</td>
</tr>
</tbody>
</table>

There has been a 6.4% increase (9.12 to 9.70) in Inpatient Days/1,000 for all youth from calendar year 2012 to 2013. The Non-DCF inpatient days/1,000 account for most of this increase, increasing by 18.7% (5.67 to 6.73) from 2012 to 2013, while the DCF Inpatient Days/1,000 decreased over the last year by 13.6% (3.45 to 2.98). Beginning in 2009, we have seen the Non-DCF Days/1,000 increase annually accounting for the majority of the increased Days/1,000, while the DCF Inpatient Days/1,000 has decreased annually.
The Inpatient Average Length of Stay (ALOS) for all youth decreased 2.8% (13.07 to 12.71) from calendar year 2012 to 2013. This is the lowest ALOS recorded in the past six calendar years. The DCF ALOS decreased 13.9% (18.02 to 15.52), while the Non-DCF ALOS increased 5.8% (11.12 to 11.77). The yearly decrease in the DCF ALOS, which was the lowest ALOS recorded for this population, was noted in both the younger children (0-12) by 3% and the adolescents (13-17) by 16%. Similarly, the increase in the Non-DCF ALOS also occurred in both age groups. The younger children (ages 0-12) increased by 5% and the adolescents (ages 13-17) increased 3%. However, the DCF ALOS continues to be higher than the Non-DCF ALOS in all calendar years.

B-C. Inpatient Psych Days in Discharge Delay vs. Acute Length of Stay

The Yearly Inpatient Percent of Days Delayed decreased by 20% from 2012 to 2013 (10.5% to 8.4%) with 9% fewer cases (177 to 161) in delay status this year. The Non-DCF population comprised 55% (N=88) of the total delayed cases (N=161) and DCF the remaining 45% (N=73).
Over the past year, the Non-DCF percent of days delayed increased by 32% (5.4% to 7.1%), and the DCF decreased by 39% (18.8% to 11.5%). Although the DCF percent of days delayed remains higher than that of Non-DCF, this is the lowest yearly percent of days delayed recorded for the DCF population.

**Discharge Delay; Child Inpatient PAR**

The percent of Discharge Delay Days for in-state pediatric hospitals fell for the fourth straight year to a low of 9.2%. This occurred even while the total number of days (Discharge Delay Days plus Acute Days) rose for the third straight year to a five-year high in 2013 of 30,318 days.

**Solnit Center Inpatient**

The number of inpatient admissions to the Solnit Center remained the same in 2013 from the previous year. The represents a 16.1% decrease from 2011 and a 23.8% decrease from the 6-year high of 185 in 2010.
Inpatient Days/1,000 decreased for the fifth straight year to a low of 4.24 days at Solnit Center. This is a 13.1% decrease from the previous year and a 41.9% decrease from 2008.

**Solnit Inpatient; ALOS – Court Ordered vs. Non-Court Ordered**

The annual Solnit Center Inpatient ALOS for all youth for 2013 decreased by 7% (120.39 to 111.71) from the previous year. The annual ALOS for the Court ordered population increased by 18% (65.3 to 76.9), and the ALOS for the Non-Court Ordered decreased by 32% (173.3 to 118.7), indicating the Non-Court ordered population was the primary driver of the decreased annual ALOS. There were 146 total discharges for 2013. The Non-Court ordered comprised 82% of the discharges and the Court ordered population, the remaining 17%.
Discharge Delay; Solnit Cases

The Percent of Days Delayed for both DCF and non-DCF members decreased in 2013 to six-year lows for both groups. The DCF members fell 5.3 percentage points to 7.0% while the non-DCF members fell 5.6 percentage points to 6.4%.

As was the case with Percent of Days Delayed, the Percent of Cases Delayed decreased for both DCF and non-DCF members to six-year lows. The DCF group dropped 12.4 percentage points to 8.6% while the non-DCF members fell 3.7 percentage points to 6.8%.

Adult Inpatient Psychiatric Hospitalization

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.

D. Inpatient Detox (IPD)

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.
E. Psychiatric Residential Treatment Facility (PRTF)

Community PRTF

There have been consistent annual decreases in PRTF Days/1,000 for all youth over the past six calendar years. Over the last calendar year, PRTF Days/1,000 have decreased by 3% (4.66 to 4.54).

The PRTF ALOS has increased and the number of discharges has decreased over the past year. There was a 1.7% (144.1 to 144.6) yearly increase in PRTF ALOS, and 13.5% fewer discharges (111 to 96) from calendar year 2012 to 2013.
The Percent of Days Delayed increased 2.5 percentage points from 2012 to 2013 from 9.5% to 11.0%. However, the DCF members increased 6.0 percentage points (from 11.9% to 15.9%) while the non-DCF members decreased 1.8 percentage points from 5.4% to 3.6%.

This year, there was a significant increase in delay for both Non-DCF and DCF members. From 2012 to 2013, the DCF percent of cases delayed increased 106% (14.9% to 30.7%) and the the Non-DCF increased 64% (7.5% to 12.3%). There were more DCF members (30.7%) in delay compared to Non-DCF members (12.3%). Across all time periods, there were more DCF members in delay, than Non-DCF in PRTF level of care.
Solnit Center PRTF

The number of Youth admissions at the Solnit Center increased 50% from Q3 '13 to Q4 '13. This is the second straight quarterly increase; and, the 24 admissions is the highest number in the last eight quarters.

PRTF Days/1,000 increased for the third straight quarter to 1.79 days in Q4 '13. This is a 15.5% increase from Q3 '13 and a 98.9% increase from the low in Q1 '13 of 0.90 days.
Residential Treatment Centers (RTC)

The percent of RTC admissions in 2013 continued a trend seen since 2011; the in-state admissions increased while the out-of-state admissions decreased. And, in both cases, the 2013 levels are at 5-year lows.

The average length of stay for RTC continued a four-year trend in 2013; the in-state ALOS decreased 10.5% to 226.63 days while the out-of-state ALOS increased 38.9% to 888.85 days. The number of in-state admissions decreased 26.8% from 2009 (from 440 to 322) while the out-of-state admissions has decreased 77.2% (from 232 to 53).
F. Day Treatment Programs Partial Hospital Programs (PHP), Intensive Outpatient Programs (IOP) and EDT

PHP

Youth admits/1,000 for partial hospitalization program continues to trends down in 2013 after reaching a high in 2009.

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.

IOP

Youth admits/1,000 for intensive outpatient program also decreased in 2013 and has been trending down since reaching a high in 2010.

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.
The number of EDT Admits/1,000 decreased for the second straight year in 2013 to 0.20. This is a 13% decrease from the previous year.

G. Home based Services (IICAPS, MDFT, MST, FFT Total)

The Home-Based Services Admits/1,000 increased for the fifth consecutive year to 1.01, an increase of 9.8% from the previous year.
There have been consistent annual increases in the Admits/1,000 for all youth to IICAP services over the past six calendar years with an 83% increase from 2008 to 2013 and an 8.5% increase in the last two years.

H. Home Health

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.

I. Ambulatory Detox (AMD)

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.

J. Methadone Maintenance (MET)

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.
K. Outpatient (OTP/TST)

Outpatient Admits/1,000 for Youth increased in 2013 to 8.02, an increase of 2.2% from the previous year. This was the second straight year this metric increased; and, 8.02 is the highest value in the last six years.

Due to anticipated updates in the membership for the final quarter of 2013, annual analysis of the adult utilization will be pended until submission of the quarterlies for Q1 2014 on June 1, 2014.

Outpatient: ECC vs. Non-ECC

The annual number of both ECC and non-ECC evaluations has continued to increase since CY ’09. There was a large increase in the volume of evaluations following the initiation of the Adult contract in Q2 ’11 and that increase has continued across calendar years 12 and 13. From CY ’12 to CY ’13 non-ECCs saw a much larger increase in total evaluations than ECCs (16.80% to 7.36% respectively).
Since CY ’09, ECCs and non-ECC Free Standing Clinics (FSCs) have reported similar total numbers of new evaluations required to meet the ECC access standards. Although similar, ECCs have always had slightly more evaluations than Non-ECC FSCs. CY ’13 was the first year where the total number of evaluations assessed against the ECC access standards were greater for Non-ECC FSCs than that of the ECCs.

Overall, the annual percent of members who were offered an appointment (routine and urgent) or who were seen within the access standard, across all three access measures, increased from CY ’12 to CY ’13. The percent of members triaged as Emergent who were seen within the access standard has been steadily increasing since CY ’07, excluding CY ’12 where this number declined to 97.39% but still remained above the access standard. Performance on the percent of members triaged as Urgent, who were offered an appointment within the access
standard, has fluctuated more than the performance on the other two access standards. The drop in this percentage in CY ‘11 and ‘12 can most likely be explained by the addition of adult members. The improvement in performance in CY ‘13 may be explained by the increased focus on meeting Urgent and Emergent access standards within the context of the new annual compliance measure for CY ‘13 which holds ECCs accountable for all 3 access standards.

### Annual Percent of Non-ECC Outpatient Evaluations Offered within Access Standard by Provider Type 2013

<table>
<thead>
<tr>
<th></th>
<th>Emergent</th>
<th>Urgent</th>
<th>Routine</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Providers</td>
<td>98.43%</td>
<td>72.59%</td>
<td>92.15%</td>
</tr>
<tr>
<td>Individual</td>
<td>99.62%</td>
<td>68.97%</td>
<td>95.24%</td>
</tr>
<tr>
<td>Free-Standing Clinics</td>
<td>92.59%</td>
<td>75.75%</td>
<td>90.78%</td>
</tr>
<tr>
<td>Hospital</td>
<td>100.00%</td>
<td>79.75%</td>
<td>87.34%</td>
</tr>
</tbody>
</table>

Numbers above the bars represent the number of members seen within the access standard

Among Non-ECC providers:

In CY ‘13, individual practitioners saw the highest volume of members triaged as needing Emergent care (262) and saw them within the 2 hour access standard 99.62% of the time. Individual practitioners also saw the highest volume of members triaged as needing Urgent care but reported offering them an appointment within 48 hours only 68.97% of the time. The non-ECC FSCs also saw a high volume of members triaged as needing urgent care and reporting having offered them an appointment within the access standard 75.75% of the time. Outpatient providers within Hospitals reported the highest rate of offering timely urgent appointments (79.75%), but their volume of urgent members was lower than those of the individual and FSC providers. Non-ECC FSCs saw the most members needing Routine care (17,620). However, the percentage of those same members offered an appointment within the access standard for CY ‘13 (90.78%) did not meet the ECC access requirement of 95%. Non-ECC individual practitioners, who treat the second highest volume of members not treated by ECCs, continue to report that they offer routine appointments at a high rate; 95.24% in CY ‘13.

Effective January 1, 2013, ECC compliance with timely access standards is being assessed on a calendar year basis rather than on a quarterly basis. The methodology was designed to provide the framework through which ECCs would be evaluated under this new annual assessment period. This new methodology included accounting for volume exemptions as well as a new rule for providers with low volume and who fell just outside of the time frame. Details are outlined below.

**Provider Compliance for CY 2013:**

**Data prior to any exemptions:**

**Routine** access compliance for the 35 ECC providers fell into the following categories:
- Met the access standard of 95%: 34
- Within 5% of meeting access standard: 1
- Below 90%: 0
- ECC(s) falling below the 95% Routine standard:
  - Hartford Hospital/IOL (92.00%)

**Urgent Access** compliance with the 2 day standard fell into the following categories:
- Number of ECCs that reported Urgent volume: 29
- Met the access standard: 17
- Within 5% of meeting the access standard: 4
- Below 90%: 8
- ECC(s) falling below the Urgent standard:
  - Middlesex Hospital Child (92.31%)
  - Child & Family Agency of SE CT – Groton (91.67%)
  - CMHA (90.91%)
  - UCFS (90.28%)
  - BHCare Valley (87.50%)
  - McCall Foundation (85.71%)
  - Community Child Guidance (78.57%)
  - Wheeler Clinic (75.00%)
  - Community Health Resources – Manchester (50.00%)
  - Southern CT Child Guidance (40.00%)
  - Clifford Beers (14.29%)
  - Catholic Charities – Norwich (0.0%)

**Emergent Access** compliance with the 2 hour access standard fell into the following categories:
- Number of ECCs that reported Emergent volume: 17
- Met the access standard: 15
- Within 5% of meeting the access standard: 0
- Below 90%: 2
  - Wellmore (75.00%)
  - CMHA (75.00%)

**ECCs remaining out of compliance on the access measures after volume exemptions were applied:**
- ECC(s) falling below the 95% standard for Routine after volume exemptions were considered:
  - Hartford Hospital/IOL (92.00%)
- ECC(s) falling below the 95% standard for Urgent after volume exemptions were considered:
  - CMHA (90.91%)
  - UCFS (90.28%)
  - BHCare Valley (87.50%)
  - McCall Foundation (85.71%)
  - Community Child Guidance (78.57%)
  - Southern CT Child Guidance (40.00%)
  - Catholic Charities – Norwich (0.0%)
- ECC(s) falling below the 95% standard for Emergent after volume exemptions were considered:
  - Wellmore (75.00%)

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Implementation of the low volume exemption:

- For Urgent cases, 2 ECCs (CMHA and McCall) were eligible for the low volume exemption, however in both instances the time frame for offered was greater than the 3 day allowance and as a result remained out of compliance.
- For Emergent cases, there were also 2 ECCs (CMHA and Wellmore) eligible for the low volume exemption. In these cases the time frame for occurred was outside the 3 hour allowance and as a result were not able to apply this exemption, thus remaining out of compliance.

Interventions to address ECC performance on Access Standards:

- A Corrective Action Plan (CAP) will be required for any measure falling below the 95% standard at the close of the year.
- For ECCs reporting zero Urgent or Emergent cases for the year, a written plan for improving triage of referral cases and/or evidence that the needs of CT BHP members are being met will be requested.
- Although the formal measurement period has transitioned to an annual span, ECCs have and will continue to receive data on a quarterly basis. This data has included both quarterly and year-to-date totals for each access standard. ECCs will continue to be notified at the close of each quarter if the standard is not met on any of the measures.

L. Develop claims-based metrics for Goal 10 F-G if claims extract is available thru DSS.

Day Treatment Programs (PHP, IOP, EDT): Admits /1000, Units /1000
Home Based Services (FST, HBS, MST, MDF, FFT, Total): Admits/1000, Units/1000

Claims-based utilization reports were not developed during 2013. See findings described in M. below.

M. Ongoing evaluation of use of Data Warehouse meeting to provide oversight of claims-based reporting and to identify changes in DSS claims data.

During 2013, the Data Warehouse Meeting was utilized to review claims data that was pulled from the DSS data warehouse as well as claims data pulled from the extract received by ValueOptions directly from HP. With the loss of two members of the group who had long-standing familiarity with the DSS data warehouse, there was a loss of expertise regarding the DSS data warehouse.

Differences between the claims data pulled from the DSS data warehouse and the claims extract were found. In some instances, more complete data seemed to be found in the extract but in others the DSS data warehouse contained more complete information. These differences impacted the IICAPS performance target results. The cohort for the study and services utilized by them was initially pulled from the extract but was later found to be missing IICAPS services claims so had to be re-pulled from the DSS data warehouse.

ValueOptions is anticipating the receipt of an enhanced claims extract from DSS in 2014. It is important that the extract be complete as the ability to house the claims data in the ValueOptions data warehouse enables us to program reports that can run routinely.
Dependency on running queries from the DSS data warehouse to populate claim-based reports is not efficient.

**Recommendations for continuing sub-Goal in 2014:**
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

**Goal 13: Monitor and update operational processes to reduce inpatient discharge delay**

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. **ASO clinicians to ensure consistent identification and documentation of discharge delay status**

All ValueOption clinicians are trained in the identification, and definition of discharge delay status. The identification and documentation of discharge delay is part of the new hire orientation checklist and training. Internal clinical workflows which outline and define the process for the identification of discharge delay serve as a guide to the daily clinical process. Clinicians participate in weekly individual supervision and staff meetings to review any facility concerns or individual cases which may identify discharge delay. Clinicians also participate in regular daily clinical rounds with management and Physicians to ensure consistent identification of discharge delay cases. Upon identification of potential discharge delay cases, the case is assigned to an Intensive Care Manager. The Intensive Care Managers participate in weekly clinical rounds with the Director of Clinical Services and leadership from DCF to review all aspects of cases on discharge delay. ICMs participate in weekly clinical rounds with inpatient units, and in the DCF area offices to review and identify potential discharge delay cases.

All clinician documentation is audited regularly for identification of cases in discharge delay. Documentation and audits are reviewed with Supervisor to ensure timely and appropriate identification of discharge delay.

B. **Establish and implement QA plan for monitoring and auditing the guidelines for discharge delay**

All Clinical staff is trained in the definition, identification and application of discharge delay. Internal workflows outline discharge delay process. All discharge delay cases are assigned an Intensive Care Manager. Clinical staff documentation is audited regularly for appropriate identification and documentation of discharge delay status, and is reviewed with Supervisors. Daily and weekly discharge delay reports have been established and are monitored to ensure the correct application of discharge delay guidelines.

C. **Work with providers to ensure consistent application of discharge delay criteria**

ValueOptions clinicians work with regional inpatient facilities to manage early identification of children and adolescents who present with potential disposition barriers leading to discharge delay status. Intensive Care managers review all HUSKY members inpatient on a weekly basis to ensure consistent early application of discharge delay criteria. Regional Network Managers also work with providers to ensure consistent application of discharge delay criteria at regular Provider analysis and reporting meetings and regular dialogue of best practices and quality concerns if applicable.
Recommendations for continuing goal in 2014:
It is recommended that this goal be sunset in 2014 as it is a performance target.

Goal 14: Ensure consistent application of activities to maintain and/or improve the rate of ambulatory follow up services after inpatient admissions – this measure is dependent on receiving regular performance updates from the state’s claims payment system

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. Review methods to ensure linkage of target population to aftercare

The connect-to-care process was developed to ensure that all members successfully transition from higher levels of care to lower levels of care. This process begins when a Provider submits a higher level of care discharge to CTBHP. A Clinical Liaison (CL) reviews the discharge forms for their region to ensure completion. If the discharge form is incomplete, a Clinical Care Manager (CCM) will outreach to the Provider in order to gain the necessary information for proper Connect to Care follow up. If a member has not connected to services, a Peer Representative will outreach to the member to see if they can be any assistance in connecting the member to an aftercare provider. When a Peer Representative is unable to connect with a member, a “Connect to Care Outreach Letter” is sent to the address on file. Peers are responsible for checking the members’ record for evidence of aftercare 30 days post discharge.

B-C. Monitor linkage efforts and performance of aftercare linkage efforts

The Connect to Care outcomes are monitored through the “Aftercare Follow-Up Rates” report, which runs on a monthly basis. The report shows the percentage of members connecting to care by day 30, post a discharge from a higher level of care. Not every member is included in follow up rate reports. Members are excluded from follow up rate reporting for several reasons such as remittance to an inpatient LOC, admittance to a LOC not authorized by CTBHP (Resi Rehab) and loss of eligibility. On average, in 2013, 79.87% of members connected to a lower level of care from a higher level of care.

Recommendations for continuing sub-Goal in 2014:
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

Goal 15: Monitor timeliness of UM decisions; identify barriers and opportunities (Contract reference: F.6, T.2 and Exhibit E Reports; 2A-2D)

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

The overall turnaround time (TAT) for initial and concurrent reviews, for both higher and lower levels of care, was well within the set standard for this evaluation period.

Overall TAT for higher levels of care (HLOC), and the percentage of cases that met the performance standard in 2013 are as follows:
- Initial Reviews: 99.95% completed within the target time (29,097 of 29,113)
Concurrent Reviews: 99.94% completed within the target time (25,303 of 25,288)

Overall TAT for lower levels of care (LLOC), and the percentage of cases that met the performance standard in 2013 are as follows:

- Initial Reviews: 99.93% completed within the target time (2,680 of 2,682)
- Concurrent Reviews: 99.83% completed within the target time (10,653 of 10,671)

A. Initial decisions re: authorization for acute levels of care (LOC) (Gen Hosp, Inpatient Psych, IP Detox, Resi Detox, PHP, IOP, Intermediate Duration Acute Psychiatric Care, Psychiatric Resi Treatment and Crisis Stab); communication within 60 minutes:

99.95% of initial decisions for acute higher level of care authorizations were communicated within the target timeframes (28,763 of 28,777).

B. Initial decisions regarding authorization for non-acute levels of care (LOC) within 1 business day:

99.93% of initial decisions for non-acute higher level of care authorization were communicated within the target timeframes (2,671 of 2,673).

C. For General Hospital/Inpatient Psych, offer an appointment for peer to peer review within 60 minutes of completion of CM review

98.48% of initial decisions for general hospital and inpatient psych authorizations that required a peer to peer review were completed within the target timeframe (130 of 132).

D. For Inpatient Detox, offer an appointment for peer to peer review within 120 minutes of completion of CM review:

100% of initial decisions for inpatient detox authorizations that required a peer to peer review were completed within the target timeframe (189 of 189).

E. Initial decision for other HLOC, offer an appointment for peer to peer review within 1 business day of completion of CM review:

100% of initial decisions for other higher level of care authorizations that required a peer to peer review were completed within the target timeframe (15 of 15).

F. Initial decision for other non-acute LOC offer an appointment for peer to peer review within 1 business day of completion of CM review:

100% of initial decisions for lower level of care authorizations that required a peer to peer review were completed within the target timeframe (9 of 9).

G. Concurrent decision re: authorization for acute LOC (Gen Hosp, Inpatient Psych, IP Detox, Resi Detox, PHP, IOP, Intermediate Duration Acute Psychiatric Care, Psychiatric Resi Treatment and Crisis Stab); communication within 60 minutes on date auth expires:
99.94% of concurrent decisions for acute higher level of care authorizations were communicated within the target timeframe (25,045 of 25,060).

H. Concurrent decisions re: authorizations for non-acute LOC within 2 business days of request:

99.84% of concurrent decisions for non-acute higher level of care authorization were communicated within the target timeframes (10,530 of 10,547).

I. Concurrent decision for General Hospital/Inpatient Psych, offer an appointment for peer to peer review within 60 min of completion of CM review:

100% of concurrent decisions for general hospital and inpatient psych authorizations that required a peer to peer review were completed within the target timeframe (176 of 176).

J. Concurrent decision for Inpatient Detox, offer an appointment for peer to peer review within 120 min of completion of CM review:

100% of concurrent decisions for inpatient detox authorizations that required a peer to peer review were completed within the target timeframe (58 of 58).

K. Concurrent decision for other HLOC, offer an appointment for peer to peer review within 1 business day of completion of CM review:

100% of concurrent decisions for other higher level of care authorizations that required a peer to peer review were completed within the target timeframe (9 of 9).

L. Concurrent decision for other non-acute LOC, offer an appointment for peer to peer review within 2 business days of completion of CM review:

99.19% of concurrent decisions for lower level of care authorizations that required a peer to peer review were completed within the target timeframe (123 of 124).

M. 98% of all authorization decisions result in a letter being available within 2 business days

In order to monitor performance of this item, a quarterly audit was conducted of a sample of authorizations from each level of care in Provider Connect. The audit looked to ensure that letters were available within two (2) business days of the authorization being created. The audit found that 100% of the authorizations audited resulted in an authorization letter being available with 2 business days of the authorization being created.

N. 98% of all batch extracts of authorization notifications created will be delivered to the vendor, who creates and mails letters, within 2 business days

Batch extracts of authorizations notifications are only occurring when authorizations are created for out of state providers. The extract has been delivered to the vendor 99.99% of the time within 2 business days.
O. Total number of Administrative Denials Issued

The total number of denials decreased 3.0% from CY ‘12 to CY ‘13. This was the first year where the total number of denials decreased. The total number of administrative denials issued to providers for the adult population also decreased (0.9% from CY ‘12 to CY ‘13) for the first time in CY ‘13. The total number of administrative denials issued to the youth population decreased by 11.4% from CY ‘12 to CY ‘13, this is a 40.6% decrease from a high of 918 in CY ‘10.

P. Total number of Medical Necessity Denials
There was a 104.6% increase in the number of medical necessity denials in CY ’13 when compared to CY ’12. The total number of denials has increased every year since CY ’10; however this the largest percent increase ever observed. The percent increase was smaller for the youth population (85.2%) than it was for the adult population (106.3 %.)

The number of medical necessity denials per authorization in CY ’13 was 0.21% (667 of 318,859) this is an increase from 0.11% in CY ’12, and 0.08% in CY ’11.

Q.  Total number of Partial Medical Necessity Denials

Out of the 641 medical necessity denials for this reason, 43 were partial denials issued for an adult member and one (1) was a partial denial issued to a youth member because:

- The services were not clinically appropriate in terms of type, frequency, timing, site, extent and duration, or not considered effective for the individual’s illness, injury or disease.

Of the partial denials, home health care services were the most frequently denied level of care for this reason accounting for 36 of the 44 denials.

R.  Number and % of Notices of Action (NOAs) and denials issued within 3 business days of decision

In CY ’13, 2,986 administrative denial notifications were sent out and 667 medical necessity denials notifications issued. All 3,653 denials, including both administrative and medical necessity were issued and sent out within 3 business days and 100.0% compliant with TAT standards.

Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 but will be split into separate goals in the 2014 Project Plan.

Goal 16: Monitor timeliness of appeal decisions; identify barriers and opportunities.  

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A - L.  Member Medical Necessity Appeals:

There were 23 member level 1 appeals for medical necessity in CY 2013. There was one appeal from a youth member. It was an expedited appeal where the member requested to talk with the doctor making the appeal decision. The majority of the member level appeals from adult members were routine (14 of 22), none of which were overturned. The remaining appeals were evenly split between expedited appeals were the member requested to talk with the doctor making a decision, and those with no meeting. The only overturned appeal was an expedited appeal for an adult member.

The number of member level II appeals varied across CY ’13 from a low of three (3) in Q1 ’13 to a high of seven (7) in Q3 ’13. Out of the 20 member level II appeals in CY ’13, one (1) was overturned, three (3) were withdrawn, and the remainder (16) were upheld.
M - R. Provider Medical Necessity Appeals:

The total number of provider appeals – level 1 for medical necessity increased by 19.2% from CY ’12 to CY ’13. The majority of provider appeals continue to be for adult members (91.4%) All appeals – level 1 were resolved within the TAT standard of one (1) business day.

There were a total of 174 provider level 1 appeals for medical necessity in CY ’13. The majority of these were from inpatient hospital providers (41.4%), followed by home health agencies (27.6%), and inpatient detox providers (16.7 %). The majority of the appeals from inpatient hospital providers came from Hartford Hospital (17 of 72) and Yale New Haven Hospital (15 of 72). There were no provider trends across the home health agencies. Southeastern Council on Alcoholism had the most appeals for inpatient detox (11 out of 29); all other detox providers had four (4) or fewer appeals.

| Member Level || Appeals | Q1 ’13 | Q2 ’13 | Q3 ’13 | Q4 ’13 | CY ’13 |
|---------------|-----------|--------|--------|--------|--------|--------|
| Upheld        |           | 2      | 5      | 6      | 3      | 16     |
| Overturned    |           | 0      | 1      | 0      | 0      | 1      |
| Withdrawn     |           | 1      | 0      | 1      | 1      | 3      |
| Total         |           | 3      | 6      | 7      | 4      | 20     |

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<table>
<thead>
<tr>
<th>Medical Necessity Provider Appeal Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult % Appealed</td>
</tr>
<tr>
<td>Adult # Appealed</td>
</tr>
<tr>
<td>Youth % Appealed</td>
</tr>
<tr>
<td>Youth # Appealed</td>
</tr>
<tr>
<td>% Appealed</td>
</tr>
<tr>
<td># Appeal</td>
</tr>
</tbody>
</table>

*Appeals rate is based on appealed cases from the current quarter’s denials, not the number of appeals for the quarter.
New methodology was established in Q4 ‘13 to determine the medical necessity appeal rate. Previously we used the total number of appeals that occurred in the measured quarter as the numerator, and the total number of denials issued in the measured quarter as the denominator. The figures above use the new methodology which continues to uses the total number denials issued in the measured quarter as the denominator but then looks at how many of those denials were appealed to use as the numerator.

After declining for the last two quarters, the overall appeal rate increased from 20.9% (41 out of 196) in Q3 ‘13 to 28.9% (37 out of 128) in Q4 ‘13 and this is accounted for by decrease in the number of denials issued. The provider appeal rate for adult members follows a similar trend to the overall rate also increasing from Q3 ‘13 to Q4 ‘13. There has been an overall decline in the provider appeal rate across CY ’13 for medical necessity denials issued for youth members. Most recently it decreased from 15.4% in Q3 ’13 to 0.0%.

<table>
<thead>
<tr>
<th></th>
<th>CY ’08</th>
<th>CY ’09</th>
<th>CY ’10</th>
<th>CY ’11</th>
<th>CY ’12</th>
<th>CY ’13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth % Overturned</strong></td>
<td>41.7%</td>
<td>31.6%</td>
<td>18.8%</td>
<td>36.4%</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td><strong>Youth # of Cases Overturned</strong></td>
<td>10</td>
<td>6</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td><strong>Adult % Overturned</strong></td>
<td>16.7%</td>
<td>27.3%</td>
<td>0.0%</td>
<td>37.5%</td>
<td>27.7%</td>
<td>24.5%</td>
</tr>
<tr>
<td><strong>Adult # Overturned</strong></td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>9</td>
<td>38</td>
<td>39</td>
</tr>
</tbody>
</table>

There were 15 provider appeals – level 1 for medical necessity for youth members in CY ’13 33.3% of which overturned. Of the 159 provider level 1 appeals for adult members, 24.5% were overturned.

There were a total of 37 provider appeals – level 2 for CY ’13. This was a 2.8% decrease from CY ’12. The majority of these appeals were for adult members (91.9 %.)
S - V. Administrative Appeals:

The total number of administrative appeals continued to increase in CY ’13. Overall, there was an 11.5% increase from CY ’12 to CY ’13. The appeals for adult members increased by 25.1%. The number of appeals for youth members decreased by 16.3% marking the second year in a row where the total number of appeals decreased.

Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 but will be split into separate goals in the 2014 Project Plan.

Goal 17: Monitor consistency of application of UM Criteria (IRR) and adequacy of documentation. (Contract Reference F.13.2)

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. Percent of compliance with clinical inter-rater reliability (IRR) audit

Annually, VO-CT engagement center participates in the company wide IRR audit. This IRR audit consisted of 20 clinical vignettes, each of which the clinicians must determine the appropriate level of care. For the past year, 100% of our clinical staff passed the IRR examination, with an average score of 96%. The average score is higher than last year, which was 93%.

In order to continue to ensure consistency with clinical decisions, clinicians meet weekly for clinical rounds and clinical trainings are scheduled weekly. Supervisors provide both weekly individual supervision as well as group supervision

B. Assess adequacy and accuracy of clinical documentation

The clinical documentation audits experienced a year of stability in 2013. For the first time in several years, no changes were made to the audit process or tool due to the successful creation of a tool and process in Q1 of 2012. The process remains collaborative between the QM auditors and the UM supervisors in the review of the documentation and listening to the calls.
The tool continued to provide feedback on areas that could be improved in order to increase the competency of care managers and identify areas that needed retraining. At the beginning of each quarter, the data from the previous quarter is reviewed with both QM and UM staff to identify trends and themes for training for the quarter. In addition, an inter-rater reliability process was conducted to ensure that all auditors were auditing in the same manner. This year, two areas were identified that required additional training – inquiring about other support services needed for member’s family and identifying the specific admission criteria that is supported by the documentation and clinical presentation. In both cases, supervision was used to address specific concerns and weekly clinical trainings were used to heighten awareness for the entire clinical staff.

Results of the documentation audits were as follows:

<table>
<thead>
<tr>
<th>Quarterly Data</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Percent with 90% or better</td>
<td>Average Score</td>
</tr>
<tr>
<td>Q1</td>
<td>93.0%</td>
<td>95.7%</td>
</tr>
<tr>
<td>Q2</td>
<td>97.6%</td>
<td>97.2%</td>
</tr>
<tr>
<td>Q3</td>
<td>97.6%</td>
<td>97.5%</td>
</tr>
<tr>
<td>Q4</td>
<td>96.9%</td>
<td>96.1%</td>
</tr>
</tbody>
</table>

Care managers have demonstrated both an increased proficiency in their audits as seen in the consistent average score over 96%, as well as the percentage of care managers getting a score of 90% or better. The stability in the care management staff has assisted in this improvement as well as the strong support that is being provided to the staff from the supervisors.

**Recommendations for continuing goal in 2014:**
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

**Goal 18: Monitor continuity of care; identify barriers and opportunities (Contract reference: I.1)**

**Description of activities and findings that include trending and analysis of the measures to assess performance over time:**

**A. Number of referrals of cases from medical ASO, ABH and other partners**

This indicator tracks the number and types of cases being co-managed by CT BHP and the medical ASO - CHN. Cases for co-management can be referred to CT BHP from CHN or vice versa. There are six automatic referrals that have been in place since CY 2008 and continue to guide the referral process. High risk pregnancy due to depression and or substance abuse, post-partum depression, child/adolescent uncontrolled diabetes, sickle cell, eating disorders, and any medical detoxes make up the existing automatic referral list.

In 2013, there were 152 cases that were co-managed by CHN and CT BHP. With CHN’s contract including VO-ICM nurses, the referrals are also made in-house. The VO-ICMs enrolled 789 members based on referrals from CHN staff. Much of the year was spent
developing the relationship with CHN and clarifying the roles of the Intensive Care Managers that both CHN and VO have to support members. It was concluded that VO-ICM nurses at CHN would support the members with SPMI and Tier 1 medical conditions (asthma, COPD, CHF, CAD or diabetes), SPMI in combination with a Tier 2 or Tier 3 medical condition would be referred to a CHN ICM. Any member with SPMI or substance abuse and any medical condition may be co-managed at the request of either ASO.

B. **In cooperation with CHN develop and implement monthly Medical ASO operations committee**

Clinical management met several times during 2013 to solidify flows for management of members who are hospitalized and require both involvement from both the medical and the behavioral ASO. Criteria for each ICM program, co-managed cases, and VO-ICM has been agreed upon and was utilized for improved triage. The clinical management teams will continue to meet as needed to update triage protocols and identify training needs.

C. **Develop and implement training medical ASO and their UM staff regarding CT BHP and coordination of care activities**

VO staff have offered training to CHN staff several times during 2013. Training has included an introduction to ICM services and Peer services, crisis call handling, CT BHP ED diversion efforts.

D. **Implement monthly meeting with designated CHN and ABH staff to review any co-managed cases**

A monthly meeting between VO and CHN clinical staff is held with the purpose of reviewing care plans for all co-managed cases. Each co-managed case is presented, follow up steps are identified and actions taken are reported. This meeting is also utilized to share best practice interventions and available resources in the community. When a specific members needs have been met, the team agrees to close the case for intensive co-managed services.

E. **Implement report to track referrals, linkage to care and co-managed cases**

The lead VO co-management clinician tracks all incoming referrals for co-management, outgoing referrals (to CHN) for co-management and referrals that are declined due to meeting criteria for an alternative ICM program. As stated above, members receiving co-management are continuously assessed for more or less intensive services. Cases are closed when members are appropriately engaged in services or are unresponsive to outreach efforts.

F. **Participation in monthly CT BHP Oversight Council’s Coordination of Care subcommittee**

The Coordination of Care subcommittee is routinely attended by VO staff; including the COO and Regional Network Managers. This subcommittee has merged with the MAPOC Consumer and Access Committee to address topics of mutual interest. VO regularly presents information related to complaints and grievances, authorizations, and coordination of care procedures with the Medical ASO.
G. **Provide ongoing Medical ASO training to CT BHP clinical staff quarterly regarding coordination activities**

CHN’s Director of ICM services trained the VO clinical staff on CHN’s ICM program. The goals of the program, criteria for program inclusion/exclusion, and opportunities for collaboration with VO were reviewed and discussed. Internally, the CT BHP co-management lead clinician trains and updates clinical staff bi-annually on the co-management program, including making referrals and expected coordination with CHN.

H. **Number of members enrolled in McKesson program**

The McKesson program was discontinued in 2013.

I. **Number of members graduated from the McKesson program**

The McKesson program was discontinued in 2013.

**Recommendations for continuing sub-Goal in 2014:**

This goal continues to be applicable for 2014 with the exception of the two McKesson related sub-goals and should be included in the 2014 Project Plan.

**Goal 19: Reduce Emergency Department (ED) Discharge Delays (Contract reference: F.17)**

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

**A - B. Number and average length of time of youth are delayed in the ED**

<table>
<thead>
<tr>
<th>Youth ED Stuck CY '10 through CY '13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Youth (0-17)</strong></td>
</tr>
<tr>
<td><strong>ED Stuck</strong></td>
</tr>
<tr>
<td>Q1</td>
</tr>
<tr>
<td>Q2</td>
</tr>
<tr>
<td>Q3</td>
</tr>
<tr>
<td>Q4</td>
</tr>
<tr>
<td>Year</td>
</tr>
</tbody>
</table>

There was a noticeable increase in youth members in ED Stuck status in 2013 with a 20.2% increase in volume between 2012 and 2013. The ALOS remained fairly stable at 1.50 days with only slight increases during predictable quarters, Q2 and Q4 which tend to have an increase in ALOS as seen over the last two years.
While the ALOS increased from 1.59 days to 1.88 days from 2012 to 2013, the number of adult members in ED Stuck status dramatically reduced over that same time period by 35.2%. Fewer members are reportedly getting stuck in the ED but the ones that are being reported to VO are getting stuck for longer periods of time – see adult frequency distribution below. The decrease in members over the course of the year may also be attributed to the change in staffing at VO with the decrease in number of ICM assigned to call the EDs, which went from seven to four for a period of time over the summer. The staffing has since returned to the original seven.

### Frequency Distribution of ED Stuck Stay

<table>
<thead>
<tr>
<th>Adult (18+)</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>ALOS</td>
<td>ALOS</td>
<td>ALOS</td>
</tr>
<tr>
<td>Q1</td>
<td>N/A</td>
<td>N/A</td>
<td>371</td>
</tr>
<tr>
<td>Q2</td>
<td>483</td>
<td>325</td>
<td>266</td>
</tr>
<tr>
<td>Q3</td>
<td>350</td>
<td>253</td>
<td>128</td>
</tr>
<tr>
<td>Q4</td>
<td>274</td>
<td>191</td>
<td>108</td>
</tr>
<tr>
<td>Year</td>
<td>1,087</td>
<td>1,140</td>
<td>739</td>
</tr>
</tbody>
</table>

While the ALOS increased from 1.59 days to 1.88 days from 2012 to 2013, the number of adult members in ED Stuck status dramatically reduced over that same time period by 35.2%. Fewer members are reportedly getting stuck in the ED but the ones that are being reported to VO are getting stuck for longer periods of time – see adult frequency distribution below. The decrease in members over the course of the year may also be attributed to the change in staffing at VO with the decrease in number of ICM assigned to call the EDs, which went from seven to four for a period of time over the summer. The staffing has since returned to the original seven.

### Frequency Distribution of ED Stuck Stay

#### Youth (0 - 17) ED Stuck Frequency Distribution

<table>
<thead>
<tr>
<th>% of Members Stuck</th>
<th>0 Days</th>
<th>1 Days</th>
<th>2 Days</th>
<th>3+ Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010 LOS</td>
<td>6.43%</td>
<td>69.51%</td>
<td>12.71%</td>
<td>11.36%</td>
</tr>
<tr>
<td>2011 LOS</td>
<td>9.59%</td>
<td>64.87%</td>
<td>13.79%</td>
<td>11.75%</td>
</tr>
<tr>
<td>2012 LOS</td>
<td>7.43%</td>
<td>67.04%</td>
<td>14.99%</td>
<td>10.53%</td>
</tr>
<tr>
<td>2013 LOS</td>
<td>12.29%</td>
<td>58.76%</td>
<td>14.43%</td>
<td>14.52%</td>
</tr>
</tbody>
</table>
The percentage of the youth population in ED Stuck status for less than a one day and three or more days is gradually increasing while the population stuck for one day decreased in 2013. Youth stuck in the ED for 2 days remained relatively stable from 2012.

In 2013, there was an increase in the percent of adults stuck in the ED 2 days and greater. The majority of adults continue to be stuck in the ED a day or less but the percentage decreased from last year.

Recommendations for continuing goal in 2014:
This goal continues to be applicable for 2014 but will be modified in the 2014 project plan to only speak to the youth population as the adult population will be addressed in the ED Performance Target.

Goal 20: Establish additional Outlier Management/Bypass programs while monitoring standards of existing program

Description of activities and findings that include trending and analysis of the measures to assess performance over time:

A. Identify data elements necessary in reporting to review for outlier status

An “outlier” is a person, program/service or facility whose measured performance lies outside the normal range of similar persons, programs, or facilities and for this reason is the object of further study. CT BHP is moving toward greater use of “outlier management” strategies. “Bypass programs” refers to a program where providers that meet or exceed performance targets on key
indicators are able to bypass the selected usual administrative requirements in the utilization management process. These involve shifting the focus of attention from routine cases to those that are more clinically challenging, or to those providers that have shown practice patterns that significantly deviate in some way from the norm in relation to other providers of the same type.

The CT BHP implemented a Bypass program for the Child/Adolescent Inpatient Psychiatric Facilities within the network during 2008. Adult Inpatient units also were included in the Bypass in 2010. IICAPS services for the Child/Adolescent population have had a Bypass Program since 2011. The benefits of a Bypass Program are that it provides administrative relief for both CT BHP, as well as providers/programs that evidence efficient and consistent ALOS. This is achieved by authorizing care for longer periods of time, thus decreasing the number of concurrent reviews required for a stay.

While ValueOptions is engaged in an iterative process with our state partners to redefine the Bypass Program using Predictive Modeling, we will continue to utilize the established metrics used to set parameters for Bypass established early in 2013.

Examples of the eligibility metrics utilized to determine the criteria for participation in the Bypass Program for inpatient psychiatric services are listed below:

- Establishment of an annually determined minimum volume of members treated during the previous calendar year, and
- An ALOS that is no greater than the annually determined number of standard deviations from the statewide average,
- A 7 day readmission rate that remains below the annually established rate
- Discharge information for all members entered via web at an annually determined rate,
- Verification that the provider has no current corrective action plans related to quality of care involving the targeted inpatient unit/s.

Proposed eligibility criteria and length of initial authorization for participants in 2014 program:
All decisions regarding participation in the inpatient psychiatric services Bypass Program will be based upon authorization data for calendar year 2013 (Q1 ’13 through Q4 ’13). Programs with:

1. A minimum of 20 members treated during calendar year 2013, and
2. An ALOS that falls within .25 Standard Deviations (SD) of the state-wide ALOS and
3. A 7 day readmission rate that remains below the established measure
4. Discharge information entered on members via web on or by the day of discharge at a 90% completion rate,
5. No current corrective action plans exist related to quality of care associated with the targeted inpatient units treating CT BHP members.

Inpatient programs that meet these qualifications would receive a 5 day initial authorization for psychiatric admissions for their population.
Criteria for determinations regarding continuing participation in the Bypass Program for inpatient psychiatric services:
Interim monitoring of inpatient psychiatric program utilization:

1. At mid-year, participant program specific ALOS for the previous six (6) months (Q1 ‘14 through the end of Q2 ‘14) will be calculated and compared to the previous calendar year ALOS.

2. At mid-year, participant program specific 7 day readmission rate for the previous six (6) months (Q1 ‘14 through the end of Q2 ‘14) will be measured against the established standard.

3. The UM staff will confirm the presence of discharge information on members discharged during the previous time period.

4. When a participating provider’s ALOS increases by more than an annually predetermined number of standard deviations from the statewide average for the previous calendar year, a CT BHP staff member will notify the provider in writing that they will have an additional quarter to bring their ALOS back in line with expectations. The provider will need to have an ALOS for that next quarter that falls within the identified range. If, at the end of the quarter, their ALOS still does not fall within the required range, they will be removed from the Bypass Program and returned to standard authorization procedures. Eligibility to return to Bypass Program participation will not be possible until the next semiannual review.

5. The UM staff will confirm with the QM Department that there are no quality improvement or corrective action plans in place for any of the proposed participants.

Annual Evaluation for determination of ongoing participation and new additions to the program

1. The required minimum number of members treated by participant will be determined based on experience with this program during the previous year.

2. Within 45 days of the end of each calendar year, the statewide ALOS and standard deviation will be calculated for the previous calendar year based upon all discharges from inpatient psychiatric services that occurred during that year.

3. The ALOS for each of the inpatient psychiatric programs will be calculated based upon those programs’ specific discharges.

4. The UM staff will review the 7 day readmission rate of each facility, and

5. The UM staff will confirm the presence of discharge information on members discharged during the previous time period.

6. The UM staff will confirm with the QM Department that there are no quality improvement or corrective action plans in place for any of the proposed participants.

These outlier management and bypass strategies are used for management of both inpatient and outpatient services. This approach will be developed, enhanced and expanded as CT BHP data are obtained to inform our decisions.
As the UM Program and the contract continues to mature, CT BHP’s Outlier Management and Bypass Program will be designed to prioritize the allocation of internal resources toward effecting change to those providers and levels of care which yield the highest results after reviewing existing data.

**Recommendations for continuing goal in 2014:**
This goal continues to be applicable in 2014 and should be included in the 2014 Project Plan.

**Goal 21: Maintain the Provider Analysis and Reporting (PARs) Initiatives for Inpatient Child and Adolescent, Enhanced Care Clinics and Psychiatric Residential Treatment Facilities, and CT Emergency Department levels of care and Implement initiatives with, Residential Treatment Centers (RTCs), and Emergency Mobil Psychiatric Services (EMPS) levels of care. (Contract reference: M.12)**

**Description of activities and findings that include trending and analysis of the measures to assess performance over time:**

During 2013, ValueOptions CT continued to use the Provider Analysis and Reporting (PAR) programs as a strategy to reform the behavioral health system of care in CT with the goal of improving the quality and efficiency of the service system. There were no additional performance improvement initiatives during 2013.

During 2013, the following PAR programs were in existence:

1. Child and Adolescent Inpatient Hospital
2. Psychiatric Residential Treatment Facilities (PRTFs)
3. Adult Inpatient Hospitals
4. Home Health
5. Youth Residential Treatment Centers and Therapeutic Group Homes
6. Enhanced Care Clinics (ECCs) for Youth and Adults

The following PAR Program was discontinued and incorporated into other PAR programs:

1. Emergency Departments

Each of these programs is evaluated below.

**Child and Adolescent Inpatient Hospitalization PAR Program**

The Inpatient Child and Adolescent PAR program initially focused on the need to address exceptionally long lengths of stay that resulted from the delays in discharge of children and adolescents being treated in inpatient psychiatric units. In 2007, the Child and Adolescent Inpatient PAR program was implemented as an method to address these long lengths of stay. The initial phase of the program included the development of a workgroup with the hospitals in CT that provided psychiatric inpatient treatment for children and adolescents. The participants shared information regarding the barriers encountered when discharging youth and worked towards developing strategies for addressing those barriers. The group agreed to work towards lowering the length of stay of youth in CT. Since that time, the length of stay has decreased from 18.3 days in 2008 to 12.1 days in 2013, a 33.9% reduction.

Throughout 2013 RNMs continued to meet with the child and adolescent hospitals to review and analyze PAR data. During 2013 emergency department data was incorporated into the
Inpatient Child and Adolescent PAR methodology and will begin to be presented in the 2014 PAR meetings.

In addition, the pediatric inpatient workgroup met three times during 2013. The early workgroup discussions focused on reviewing findings from the previous Performance Initiative that included a plan for bonus incentives, however, the group concentrated on other statewide trends and best practices after the funding was cut to this program. One of the findings that came out of the workgroup was the continuing need to improve ambulatory follow-up. To address this issue, it was determined that a second round of Connect-to-Care meetings across the state would be held. From May through August 2013, the RNMs held six Connect-to-Care meetings with the hospitals and other providers to continue to find ways to improve connections to community providers following discharge from inpatient units.

With the decrease in capacity for children at Solnit Hospital's inpatient unit, the PRTF providers were included in the last workgroup meeting of the year. The objective was to begin discussions around the status of the need for this level of care, what challenges existed, if any, and to promote relationships between the inpatient providers and the PRTF providers.

Going forward, the pediatric workgroup will need to clarify its scope and goals as they related to strengthening the pediatric inpatient behavioral health system. The PAR program will continue to support the hospitals by reviewing the data measures and collaboratively developing strategies and initiatives to make improvements to the system of care where needed.

The Inpatient Child and Adolescent PAR program will continue during CY 2014 with a continued emphasis on reducing discharge delay, reducing length of stay and better connecting members to care at discharge from the hospital.

**Adult Psychiatric Inpatient PAR Program**

Given the success of the Pediatric Inpatient PAR program, the CT BHP implemented an Adult Psychiatric Inpatient Hospital PAR Program in CY 2012.

A first round of hospital-specific adult inpatient PAR meetings to present Q3 '12 data was held during the last quarter of 2012 via face to face meetings, conference calls, or emails to all inpatient psychiatric hospital facilities in CT. In CY 2013 hospital-specific inpatient PAR profiles were produced and another round of quarterly PAR meetings was held.

Based upon the discovery in 2012 that hospitals were not consistently reporting and requesting authorizations for members eligible for both Medicaid and Medicare, the methodology was changed to remove dually eligible members from the data in 2013. In addition, ValueOptions developed an electronic data dashboard for the adult inpatient data in CY 2013 and introduced the dashboard to providers. The dashboard replaces the paper profiles and provides data that is refreshed on a daily basis.

Following upon the success of the regional Connect to Care meetings held with pediatric hospitals in 2012, in CY 2013 CT BHP RNMs held regional Connect to Care meetings with adult hospitals and invited selected community providers, focusing on ensuring timely and smooth transitions to other levels of care following discharge from an inpatient facility. As a result of these meetings, the Middlesex Community Care Team was identified as a best practice and the CT BHP introduced this model to other hospitals during the last round of CY 2013 PAR meetings.
Having determined in 2012 that it was inefficient to hold separate PAR meetings with Inpatient and ED staff, in CY 2013 ValueOptions worked on developing methodology to incorporate the ED performance measures within the Inpatient PAR. The new ED performance measures will be rolled out to both Inpatient and ED staff in the second quarter of 2014.

The major objectives of the Adult Inpatient Psychiatric Workgroup in CY2013 were continuing to build relationships with the Adult Inpatient hospital representatives, assisting hospitals in the development and establishment of community care teams, an emerging “best practice” in care coordination, on-going development of predictive modeling methodology, and the roll-out of Adult electronic Psychiatric Inpatient dashboard.

An Adult Inpatient Psychiatric Workgroup was held on March 26, 2013, with a total of 16 hospitals participating. The discussion focused on the implementation of the on-line concurrent review process for inpatient units on the by-pass. Hospitals continue to report barriers impacting average length of stay (ALOS) including probate related matters, waiting for state beds, residential rehabilitation beds, accessing appointments with LMHA, and homelessness.

As a result of provider feedback from the previous workgroup a portion of the July 30th Adult Inpatient Psychiatric Workgroup agenda focused on a presentation/update by Department of Mental Health & Addiction Services (DMHAS) representative in regards to DMHAS-funded recovery houses throughout the state. Predictive modeling was introduced and discussed as the next step in determining methodology to predict length of stay based on a variety of variables. Probable variables include probate, homelessness, prior admits to hospital, age, gender, race/ethnicity and diagnosis. It was predicted that lengths of stay will vary statewide based upon hospital populations/demographics.

Based upon themes identified in the recent statewide Connect to Care meetings, one of which was the need for improved communication among providers, in lieu of the regular CTBHP quarterly Adult Psychiatric Inpatient workgroup format, the workgroup was expanded to host a statewide community care team (CCT) presentation in addition to regional break-out sessions to further discuss potential and interest in implementing similar practices in the respective regions. Presentations were provided by two hospitals, Middlesex & Yale, and one LMHA, Southeastern Mental Health Authority. The varied models demonstrated efforts to address the management of individuals with high utilization and needs related to inpatient, ED and community treatment services. Populations to be addressed will also include those needing medical and behavioral health integration as well as those who are homeless.

RNMs will continue to work with hospitals and community providers to implement regional Community care Teams during 2014.

The Adult Psychiatric Inpatient Hospital PAR program will continue during CY 2014.

**Psychiatric Residential Treatment Facilities (PRTF) PAR Program**

The Psychiatric Residential Treatment Facility (PRTF) Program began in 2008 in response to the need for a more efficient referral process to PRTF level of care. Since the inception of the PRTF program, the average length of stay has decreased by 55% (338 days to 152 days). The decrease in ALOS has led to greater availability of PRTF beds and, at times, an increase in admissions. PRTF data includes the following measures: number of admissions, average length of stay, percentage of members in discharge delay status, percentage of days spent in discharge delay status and PRTF days/1000.
The statewide capacity of PRTF beds experienced significant changes in 2012. The child PRTF program (12 and under) at Klingberg Family Centers closed. During 2013, 22 new adolescent PRTF beds for girls were created at Solnit Center South and 36 PRTF beds for boys were created at Solnit North.

The 2013 PRTF Program Goals and Objectives included:

1. To improve care transitions with increased family engagement and cross-continuum collaboration with other providers/care settings

2. To inform and align individual PRTF program strategic planning activities with statewide system goals through the use of PAR data and/or other performance improvement tools

The statewide PRTF Workgroup met twice in February and July in order to analyze and review data and receive DCF updates. The twice yearly schedule was selected due to the relatively small number of admissions/discharges per program and the difficulty interpreting data with small n’s if presented quarterly. For the Fall Quarterly meeting, the PRTF programs joined the Statewide Pediatric Psychiatric Inpatient Workgroup in order to enhance the discussion around care transitions, specifically with regards to discharge delay and the transition between inpatient and PRTF level of care.

Program-specific meetings were also held as needed on an ad-hoc basis throughout the year in order to discuss program data, key quality improvement areas and to strategize around targeting specific opportunities for improvement. These meetings included representation from the ValueOptions Network/Quality Management team with DCF leadership and licensing staff.

The Psychiatric Residential Treatment Facility PAR program will continue during CY 2014, with the same program goals and objectives.

**Home Health PAR Program**

A key goal for the CT BHP is to support the movement towards recovery for members receiving Home Health services. The objective of this goal is to increase the autonomy and self-sufficiency of members utilizing home health services by decreasing the unnecessary utilization of medication administration services particularly for those members receiving daily or twice daily medication administration. This may also decrease the duration and frequency for which members receive Home Health services overall.

During late 2011, a workgroup comprised of Home Health agency representatives and CT BHP representatives from DSS, DMHAS, and ValueOptions was formed for the purpose of developing a PAR Program for the Home Health agencies. The workgroup met several times in late 2011 and continued to meet in 2012 to identify measures that would allow for the assessment and promotion of movement towards independence in medication administration.

By April 2012, the decision was made to roll out the Home Health PAR Program. Due to the large number of Home Health agencies, it was determined that the PAR program would include providers that serve a minimum of 75 utilizers with primary behavioral health diagnoses per quarter. As of Q3 ’11, 15 Home Health agencies met this criteria. These 15 agencies provided services to 88% of all members receiving Medication Administration services in Q2 ’12. The Home Health RNM met with all 15 Home Health agencies in CY 2013 to share and analyze their PAR data.
The Home Health PAR Workgroup continued to meet throughout 2013. The workgroup focused on the following:

- Review of the Home Health PAR data
- Barriers to increasing client self-sufficiency and reducing service frequency
- Challenges and opportunities to improve connect-to-care for members receiving Home Health services
- Revision of the Home Health level of care guidelines
- Medication administration in residential care Homes (RCHs)

The CT BHP held a meeting with the State partners, the Department of Public Health and the Residential Care Home trade association to discuss the use of home health agencies for medication administration and training of RCH staff to do medication administration.

The Home Health PAR program will continue during CY 2014.

Enhanced Care Clinic (ECC) PAR Program

The Enhanced Care Clinic (ECC) PAR program followed a unique progression when compared to other CT BHP PAR programs. In the case of the ECCs, providers received incentive payments prior to demonstrating that they could meet the expectations of their agreement for the following:

1. Centralized telephonic access to appointments
2. Timely access to care including:
   a. Routine appointments offered within 14 days 95% of the time
   b. Urgent appointments offered within 48 hours 95% of the time
   c. Emergency evaluations within 2 hours of arrival at the ECC 95% of the time
   d. Psychiatric evaluations within 2 weeks of evaluation when the need for psychiatric evaluation was identified
   e. Extended clinic hours
3. A signed Memorandum of Understanding (MOU) with PCPs or Pediatricians in their areas providing consultation and timely access to those providers so that they may in turn provide psychopharmacologic treatment to HUSKY members within their practices.
4. Screening for co-occurring disorders

During 2013, there were 34 primary ECC clinics and 49 secondary sites, totaling 83 statewide locations. Beginning at the end of CY 2012 and continuing throughout CY 2013 surveys were conducted at all ECCs. After results were compiled, letters were sent to two ECCS notifying them that they had passed their audits. All remaining ECCs received letters notifying them that they had not passed certain elements of the survey and requiring that they establish Corrective Action Plans (CAPs) to address these deficiencies. ValueOptions RNMs assisted the ECCs in developing and implementing CAPs. CAPs were approved by the State and the majority of the follow-up surveys were conducted during the second half of 2013. A small number of follow-up surveys remain to be completed in 2014, so final results from this round of surveys is not yet available.

Throughout 2013 RNMs continued quarterly contact with ECC providers to provide data details. Quarterly mystery shopper calls continued to be placed, with three ECCs receiving calls each...
quarter. During 2013 all ECCs that were mystery shopped passed on either the first or follow-up call.

The ECC Provider Workgroup on Capacity and Access continued to meet on a quarterly schedule throughout 2013 and continued to review and analyze the impact of capacity on provider compliance for the ECC access standards. Since its inception the ECC program has significantly improved the initial access to outpatient care for children, adolescents and their families. Maintenance of the program is believed to be essential to maintaining the gains regarding access, coordination with primary care and co-occurring competence.

The ECC PAR program will continue in CY 2014.

**Residential Treatment Center (RTC) PAR Program**

In late 2008, a workgroup made up of DCF and ValueOptions staff began working together to develop several reports, identified in collaboration with RTC providers, that would allow DCF to assess RTC performance. Several of the reports were based entirely or in part on CT BHP authorization data. In other instances, the CT BHP worked collaboratively with DCF staff to develop data collection tools for DCF’s ongoing use that would assist them to collect the data necessary for the reports by conducting chart and file audits. In 2010, a PARs profile for each of the in-state RTCs had been completed that included all 13 of the measures. In 2011, while the profiles were continued, some of the measures were deleted when, as a result of staffing changes within DCF, the measures that were dependent upon DCF staff were curtailed.

During 2013, the RNMs held PAR meetings with RTC providers, delivering Q4 2012 data. The data included the following measures: average length of stay; length of stay frequency distribution; provider-specific event rates including suicide attempts, AWOLs, arrests, police calls and restraints; monthly treatment hours; and percentage of youth hospitalized during the stay.

Midway through 2013, the RTC PAR was put on hold pending the signing of the PIC contract.

**Therapeutic Group Home PAR Program**

The PAR program for Therapeutic Group Homes (TGHs) was established in 2012. During 2013, the RNMs held PAR meetings with TGH providers, delivering Q4 2012 data. The data included the following measures: average length of stay; length of stay frequency distribution; provider-specific event rates including suicide attempts, AWOLs, arrests, police calls and restraints; monthly treatment hours; and percentage of youth hospitalized during the stay.

TGH providers reported several significant barriers to discharge. Lack of foster families and lack of families willing to take older adolescents are significant barriers, contributing to longer lengths of stay. Some providers report that they are not getting a concurrent discharge plan from area offices, also contributing to longer stays. Providers also report that there are barriers to family therapy including lack of transportation for family members and family members being unwilling to participate.

Midway through 2013, the TGH PAR was put on hold pending the signing of the PIC contract.

The TGH PAR program will be discontinued in 2014 with quality improvement activities for group homes shifting to the Performance Improvement Center (PIC). The TGH PIC will
incorporate many of the measures developed under the PAR program and will incorporate new measures and strategies (training, program standards, etc.) to improve care and outcomes.

**Recommendations for continuing sub-Goal in 2014:**
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

**Goal 22: Work with Psychotropic Medication workgroup to develop new reports and possible interventions regarding the use of psychotropic medications (Contract reference: I.7)**

**Description of activities and findings that include trending and analysis of the measures to assess performance:**

As previously described in the 2012 QM Program Evaluation, in October of 2012, DSS established a Psychotropic Medication Workgroup that included representatives from DSS, DMHAS, DCF, and ValueOptions. The workgroup focused on developing two projects: one to focus on adults and the other to focus on youth. DMHAS staff were responsible for the development of a study regarding the impact of psychotropic medications on metabolism in adults and ValueOptions was responsible for developing a report concerning the use of more than one antipsychotic for more than 30 days in youth.

By the end of 2012, a template for the report on youth had been developed and critiqued by members of the workgroup. The report requested was a detailed list of the names of all youth who filled prescriptions for more than one antipsychotic during the month, the name of the drugs, the dosages, the age of the youth, the DCF status of the youth, the prescriber name, and the NPI number of the prescriber.

In May, 2013, the workgroup reconvened to review the report for youth. The data for the report was based on pharmacy claims for all of CY 2012. A total of 291 unique youth appeared on the list at least once. A total of 181 prescribers had prescribed two or more antipsychotics for more than 30 days for Non-DCF youth; 85.6% (155) of those prescribers had prescribed two or more antipsychotics for more than 30 days for two or fewer youth. A total of 110 prescribers appeared on the list for DCF youth; 84.5% (93) had prescribed for two or fewer youth. In almost every instance, a single prescriber had written all of the scripts for the youth with two or more antipsychotics. The most frequent combinations of antipsychotics were Seroquel and Risperidone or Seroquel and Abilify. A detail report of the youth was given to the DCF Medical Director on the committee.

In January, 2014, a detail report was produced that covered the last four months of 2012 and the first six months of 2013. A summary of the youth included in that report is as follows:

<table>
<thead>
<tr>
<th>Age 4-6</th>
<th>Sept '12</th>
<th>Oct '12</th>
<th>Nov '12</th>
<th>Dec '12</th>
<th>Jan '13</th>
<th>Total Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth 1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Youth 2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Number of Members by Month with Multiple Antipsychotics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept '12</td>
</tr>
<tr>
<td>----------</td>
</tr>
<tr>
<td>41</td>
</tr>
</tbody>
</table>
Only two youth between the ages of 4 and 6 were on two or more antipsychotics for more than 30 days. One youth remained on two or more antipsychotics for five (5) months.

<table>
<thead>
<tr>
<th>Age 7-10</th>
<th>Sept '12</th>
<th>Oct '12</th>
<th>Nov '12</th>
<th>Dec '12</th>
<th>Jan '13</th>
<th>Feb '13</th>
<th>March '13</th>
<th>April '13</th>
<th>May '13</th>
<th>June '13</th>
<th>Total Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth 1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Youth 2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>2</td>
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<td>Youth 3</td>
<td>1</td>
<td>1</td>
<td>1</td>
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<td>1</td>
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<td></td>
<td>8</td>
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<td>Youth 4</td>
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<tr>
<td>Youth 5</td>
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<td></td>
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<td>2</td>
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<td>Youth 6</td>
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<td>1</td>
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<td>Youth 7</td>
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</tbody>
</table>

A total of 10 youth between the ages of 7 and 10 were on two or more antipsychotics for more than 30 days during this time period. The length of time ranged from 2 (50%) to 8 months.

A total of 19 youth between the ages of 11 and 13 met the criteria for inclusion on the report. The length of time on two or more antipsychotics was from one (1) to 10 months.

A total of 33 youth between the ages of 14 to 18 met the criteria for inclusion on the report. The length of time ranged from two (2) to 10 months. A total of six (6) of the 33 youth in this age category (18.2%) were on two or more antipsychotics for more than 30 days.

On review of this report, the committee concluded that this report should be produced monthly.

A monthly detail report will be produced for DCF’s review during 2014. The report will be also be reviewed by one of the ValueOptions child psychiatrists. A summary of the trends by prescribers writing prescriptions for two or more antipsychotics will be reviewed with the committee in addition to a review of the detail report.

**Recommendations for continuing sub-Goal in 2014:**
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.

**Goal 23: Work with the Departments to establish new methods for assessing provider network adequacy (Contract reference: O.4.1.4)**

**Identify providers who are not accepting new Medicaid referrals and place them in a No Referral Status**

In order to continue to identify providers that were not accepting new Medicaid members, a process was established whereby all staff talking with members inform provider relations via the VO MIS of providers no longer taking referrals. When members identify providers that are not accepting new Medicaid members, the provider information is documented and forwarded to the provider relations department for follow up. Provider relations staff members outreach to the
provider and determines if the provider is in fact not accepting additional referrals. Once the provider’s status is confirmed, the provider is then placed in a No Referral status.

A survey of providers was conducted in 2012 but due to the low volume of responses, the decision was made to conduct the provider survey every two years. The survey will be conducted again in 2014.

The efforts of the Provider Relations department in 2013 was focused on the enrolling of providers that are ordering, prescribing and referring (OPR) only and have not otherwise enrolled in Medicaid. The Affordable Care Act (ACA) mandated that ordering, prescribing and referring providers who render services to HUSKY clients be enrolled in the Connecticut Medical Assistance Program (CMAP). Claim edits went into effect on May 1, 2013 to indicate those providers that were not enrolled and to assess impact. Effective September 3, 2013, if a provider was not enrolled in CMAP or was not an OPR provider, pharmacy claims would deny with edit 207: Prescribing provider not enrolled. Claims for prescriptions and refills with dates of service on or after October 1, 2013 would deny if the submitted Prescribing Provider NPI was not actively enrolled with the CMAP.

Beginning in August of 2013, VO began receiving weekly claim reports indicating non-enrolled prescribing behavioral health providers. Weekly conference calls were held with representatives from DSS, HP and CHN to draft outreach and escalation procedures and held meetings with DCF to discuss and synchronize outreach efforts. VO began outreach calls to encourage and clarify the Medicaid and OPR enrollment process. In September, VO concentrated outreach efforts to providers with 100+ clients, collaborated with providers, refusing enrollment, to determine a notification and transition plan for existing clients and collaborated with Home Health Providers to increase outreach efforts. October through December, VO Provider Relations continued outreach calls and the Community Peer Department began direct outreach to members to encourage their providers to enroll and/or assist with transition plan to an enrolled provider. Between August and December, the VO made outreach calls to over 1,200 providers and over 1,200 members.

**Ambulatory follow-up rates will be programmed by the end of 2013 and will be useful for determining network adequacy.**

Ambulatory follow-up rates based on HEDIS specifications were programmed during 2013 and were reported for 2011 and 2012. The HEDIS ambulatory follow-up rates are based on both claims data and DMHAS encounter data. ValueOptions, CT authorization data were also used in order to identify youth who were transferred from an inpatient stay to an RTC or to a Group Home, as no claims data is available for these levels of care.

The HEDIS ambulatory follow-up measure identifies the rate at which members from 6 years old to 65+ who are discharged from an acute care psychiatric hospital with a mental health diagnosis and who return to the community, receive a visit with a behavioral health provider within 7 and 30 days. Members who are transferred to any type of congregate care setting (e.g., rehabilitation, state hospital, nursing home, etc.) are excluded from this measure. Members must also be eligible for Medicaid services during the 30 days following discharge.

The value of the HEDIS measures lies in the ability to access comparison data. HEDIS results are reported for national and regional averages and percentiles for Commercial, Medicaid, and
Medicare populations. Health plans who report their HEDIS data must have their data audited before it is posted and included in the calculation of the normative data.

The following ambulatory follow-up rates were found for 2011 and 2012. Please note:

**Youth Ambulatory Follow-up Rates:**

### 7 Day Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>CT Youth 7 Day Rate</th>
<th>National HMO Average</th>
<th>Regional HMO Average</th>
<th>Regional Percentiles</th>
<th>Comparison to Regional Medicaid Product *</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>68.68%</td>
<td>44.56%</td>
<td>55.81%</td>
<td>75th Percentile: 67.49%</td>
<td>59.94%</td>
</tr>
<tr>
<td>2012</td>
<td>72.48%</td>
<td>46.50%</td>
<td>67.90%</td>
<td>75th Percentile: 71.71%</td>
<td>60.07%</td>
</tr>
</tbody>
</table>

Range of CT Hospitals treating youth:

2011: Natchaug Hospital (64.82%; 164/253) Manchester Memorial Hospital (80.52%; 62/77)
2012: Waterbury Hospital (67.65%; 46/68) Natchaug Hospital (75.97%; 196/258)

### 30 Day Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>CT Youth 30 Day Rate</th>
<th>National HMO Average</th>
<th>Regional HMO Average</th>
<th>Regional Percentiles</th>
<th>Comparison to Regional Medicaid Product *</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>87.76%</td>
<td>63.83%</td>
<td>73.78%</td>
<td>90th Percentile: 86.82%</td>
<td>78.03%</td>
</tr>
<tr>
<td>2012</td>
<td>88.31%</td>
<td>64.99%</td>
<td>84.57%</td>
<td>75th Percentile: 87.45%</td>
<td>80.21%</td>
</tr>
</tbody>
</table>

Range of CT Hospitals treating youth:

2011: Waterbury Hospital (78.57%; 33/42) Manchester Memorial Hospital (94.81%; 73/77)
2012: St. Francis Hospital (84.21%; 144/171) Natchaug Hospital (91.47%; 236/258)

*United Healthcare of New England, Inc., Medicaid Managed Care Operations

Ambulatory follow-up rates for CT Medicaid youth are very good. For the 7 day rate, CT was above the 75th percentile for the northeast region in both 2011 and 2012. This indicates that access to ambulatory follow-up for CT Medicaid youth is good in most regions of the state. Some hospitals fell below the 75th percentile during both years. RNMs will be working with those hospitals to identify barriers so that they can improve their rate.
While the focus is on obtaining high rates of ambulatory follow-up within 7 days, the 30 day rate is also reported. CT was above the 90-th percentile for the northeast region in 2011 and above the 75-th percentile in 2012.

**Adult Ambulatory Follow-up Rates:**

### 7 Day Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>CT Adult 7 Day Rate</th>
<th>National HMO Average</th>
<th>Regional HMO Average</th>
<th>Regional Percentiles</th>
<th>Comparison to Regional Medicaid Product *</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>52.43%</td>
<td>44.56%</td>
<td>55.81%</td>
<td>50&lt;sup&gt;th&lt;/sup&gt; Percentile: 62.78%</td>
<td>59.94%</td>
</tr>
<tr>
<td>2012</td>
<td>54.03%</td>
<td>46.50%</td>
<td>67.90%</td>
<td>50&lt;sup&gt;th&lt;/sup&gt; Percentile: 70.12%</td>
<td>60.07%</td>
</tr>
</tbody>
</table>

**Range of CT Hospitals treating adults:**

2011: Griffin Hospital (32.43%; 12/37) Midstate Medical Center (72.55%; 37/51)
2012: State of CT (45.0%; 72/160) Midstate Medical Center (67.12%; 49/73)

The 7 Day rate of ambulatory follow-up for adults fell below the 50<sup>th</sup> percentile for the northeast region in both 2011 and 2012. While some hospitals who treat the adult population obtained rates above the 50<sup>th</sup> percentile, most fell below. These rates will be the primary focus of the next statewide meeting of the CT hospitals that treat the adult population. Barriers to obtaining timely follow-up appointments will be identified and action plans established to improve rates of follow-up. Access to services may play a role in these low ambulatory follow-up rates.

### 30 Day Rate

<table>
<thead>
<tr>
<th>Year</th>
<th>CT Adult 30 Day Rate</th>
<th>National HMO Average</th>
<th>Regional HMO Average</th>
<th>Regional Percentiles</th>
<th>Comparison to Regional Medicaid Product *</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>75.38%</td>
<td>63.83%</td>
<td>73.78%</td>
<td>50&lt;sup&gt;th&lt;/sup&gt; Percentile: 81.61%</td>
<td>78.03%</td>
</tr>
<tr>
<td>2012</td>
<td>74.08%</td>
<td>64.99%</td>
<td>84.57%</td>
<td>50&lt;sup&gt;th&lt;/sup&gt; Percentile: 85.10%</td>
<td>80.21%</td>
</tr>
</tbody>
</table>

**Range of CT Hospitals treating adults:**

2011: State of CT (69.0%; 69/100) Midstate Medical Center (86.27%; 44/51)
2012: Stamford Hospital (62.50%; 90/144) Charlotte Hungerford Hospital (85.12%; 103/121)
*United Healthcare of New England, Inc., Medicaid Managed Care Operations

While the 30 day rates are better than 7 day rates, they are still below the 50th percentile for the region. These rates will also be reviewed with the hospitals treating adults in the upcoming statewide meeting of the hospitals treating adults in CT.

**Recommendations for continuing sub-goal in 2014:**
This goal continues to be applicable for 2014 and should be included in the 2014 Project Plan.
V. ONGOING QM/UM GOALS OBJECTIVES TO BE CARRIED FORWARD FROM THE EVALUATION YEAR

Goal 1. Review and approve the 2013 ValueOptions, CT QM/UM Program Evaluation, 2014 ValueOptions, CT QM Program Description, UM Program Description and QM/UM Project Plan.

Goal 2. Ensure timely response and resolution of member/provider complaints and grievances.

Goal 3. Promote patient safety and minimize patient and organization risk from quality of care/service concerns and adverse incidents.

Goal 4. Establish and maintain CT-BHP-specific policies and procedures (P&Ps) in compliance with contractual obligations that govern all aspects of CT BHP operations.

Goal 5. Establish and maintain a training program.

Goal 6. Ensure timely telephone access to CT BHP.

Goal 7. Develop and implement clinical issues studies (one child and two adult).


Goal 9. Assure Utilization/Care Management Department compliance with established UM standards.

Goal 10. Monitor compliance with individual standards for compliance with ICM caseload expectations.

Goal 11. Monitor for under- or over-utilization of Behavioral Health Services; identify barriers and opportunities.

Goal 12. Ensure consistent application of activities to maintain and/or improve the rate of ambulatory follow up services after inpatient admissions.

Goal 13. Monitor timeliness of UM decisions; identify barriers and opportunities.

Goal 14. Monitor Medical Necessity and Administrative Denials; identify barriers and opportunities.

Goal 15. Monitor timeliness of appeal decisions; identify barriers and opportunities.

Goal 16. Monitor consistency of application of UM Criteria (IRR) and adequacy of documentation.
Goal 17. Monitor continuity of care; identify barriers and opportunities.

Goal 18. Reduce emergency department (ED) discharge delays.

Goal 19. Establish additional outlier management/bypass programs while monitoring standards of existing programs.

Goal 20. Maintain the Quality Improvement Activities: Provider Analysis and Reporting Programs.

Goal 21. Work with the Psychotropic Medication Workgroup to develop new reports and possible interventions regarding the use of psychotropic medications

Goal 22. Work with the Departments to establish new methods for assessing provider network adequacy
VI. SIGNATURE PAGE

ValueOptions, CT Engagement Center
Quality Management/Utilization Management

The ValueOptions, CT Engagement Center Quality Management Committee has reviewed and approved the 2013 Quality Management/Utilization Management Program Evaluation, 2014 Quality Management Program Description, Utilization Management Program Description, and Work Plan:

Program Approval: ___________________________  Date: __________
Robert Plant, PhD
Senior VP of Quality and Innovation

Program Approval: ___________________________  Date: __________
William Evans, MD
Chief Medical Director

Program Approval: ___________________________  Date: __________
Ann Phelan, MA
VP of Recovery and Clinical Operations

Program Approval: ___________________________  Date: __________
Steve Moore, PhD
Chief Operating Officer

The Company Quality Council (CQC) has reviewed and approved the 2013 Quality Management Utilization Management Program Evaluation, 2014 QM Program Description, 2014 UM Program Description and 2014 QM/UM Work Plan:

Program Approval: ___________________________  Date: __________
Deborah Hirschfelder, MSMA
Senior Vice President, Quality Services
Chair, Company Quality Council

Program Approval: ___________________________  Date: __________
Janice Maurizio, LCSW-R ACSW
National Senior Vice President of Clinical Services